Emergency Preparedness Training Needs Assessment
Final Report
Contract Number 601-619-TR2

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Prepared by the Institute for Innovation in Health and Human Services
James Madison University
Harrisonburg, Virginia

Christopher B. Nye

Jon M. Thompson, Ph. D.

H. Richard Travis, Ph. D.

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I. Introduction

The Department of Health Sciences at James Madison University and the Institute for Innovation in Health and Human Services developed a Memorandum of Agreement with the Virginia Department of Health Emergency Preparedness and Response Programs. The goal of this research project was to ascertain the emergency preparedness training needs of (1) safety officers in general, community, acute care hospitals, (2) hospital infectious disease coordinators, and (3) emergency room physicians and nurses.

The contact period was from September 15, 2003 until December 31, 2003. A Contract Modification Agreement was signed on November 18, 2003 changing the completion of (1) safety officers in general, community, and acute care hospitals and (2) hospital infectious disease coordinators needs assessments by December 31, 2003 and (3) emergency room physicians and nurses by February 15, 2004. An Interim Report was prepared on December 31, 2003 and contained the results of the Safety Officers and Infectious Disease Coordinators needs assessments. This final report also includes the emergency room physicians and nurses needs assessment.

Safety/Security Officers in General, Community, Acute Care Hospitals

A search was performed to find existing surveys that could be used to assess the emergency preparedness training needs of safety/security officers in the 90 general, community acute care hospitals in Virginia. Julia Miller (jmiller@neha.org), Terrorism Response Coordinator at the National Environmental Health Association, was very helpful in obtaining copies of several existing surveys. Examples of surveys eventually reviewed included: National Environmental Health Association Chemical and Bioterrorism Needs Assessment, Denver Metropolitan Medical Response System (MMRS) Hospital Survey for Disaster Preparedness, Colorado Department of Public Health and Environmental Bioterrorism Capability and Needs Assessment Survey, Association for Professionals in Infection Control and Epidemiology, Inc. Mass Casualty Disaster Plan Checklist: A Template for Healthcare Facilities, Department of Justice Performance Assessment – Emergency Preparedness Demographic Inventory, and CDC Bioterrorism & Emergency Readiness Competencies for All Public Health Workers. These surveys addressed a broad range of topics but were not specifically directed to the training needs of safety/security officers.

We also contacted other researchers in this subject area, and no specific instruments for safety/security officers were found. Thus, a questionnaire was developed for Virginia hospital safety/security officers based upon readings and interviews with professionals in the field. The questionnaire was reviewed and approved by the James Madison University Institutional Review Board (IRB), and the Virginia Department of Health.

The questionnaire was reviewed for content validity and readability by a member of the International Association for Healthcare Security and Safety. In addition, a focus group of 10 members of the Virginia Chapter of the International Association for Healthcare Security and Safety reviewed a draft of the survey at its November 13, 2003 meeting in Virginia Beach, Virginia. Suzi Silverstein of the Virginia Department of Health and Steve Ennis at the Virginia Hospital and Healthcare Association were very helpful in supplying an updated list of general, acute care community hospitals as classified by the six State Hospital Planning Regions.

The questionnaire (Appendix A) was mailed to the Director of Safety/Security at each hospital from the list supplied to us. The questionnaire was mailed the third week of November, and there were two follow-up reminder letters sent a week apart. In the middle of December, telephone calls were made to remind the Safety/Security Director to return the questionnaire. The questionnaire package contained a cover letter, the questionnaire, and request for a $ 25 premium incentive. Two self-addressed envelopes were provided marked "Completed Questionnaire" and "Premium Request" so that the responses to the questionnaire were completely anonymous.

The questionnaire has sections on Organization Data, Perception of Emergency Preparedness and Response, and General Questions. The likert-type questions were coded and analyzed by SSPS 11.5 for Windows and the open-ended question summarized.

II. Results of Safety/Security Questionnaire

Description of the Sample

Eighty-eight (88) questionnaires were sent to safety/security officers at general, acute care hospitals in the six Virginia State Hospital Emergency Planning regions. Thirty-four (38.6%) were returned with the following distribution:

Region	n	%
North	5	14.7%
Central	3	8.8%
East	8	23.5%
Northwest	7	20.6%
Southwest 1	7	20.6%
Southwest 2	3	8.8%
No identifier	1	2.9%
	34	100%

Seventy-seven percent of responding hospitals were non-profit facilities. The average size of the responding hospital was 222 beds, with an average hospital FTE of 1096. The average number of safety/security staff at responding hospitals was 15.

Perception of Emergency Preparedness and Response (Questions 1-10)

A likert scale of Strongly Agree (SA), Agree (A), Neutral (N), Disagree (D), and Strongly Disagree (SD) was used for questions 1-10. Questions 1-9 also had individual ratings for biological, chemical, nuclear/radiological, and explosive (BCNE) events to indicate if there were different perceptions of readiness for different events. SPSS was used to display frequencies and cross tabulations between planning regions. Responses to questions are summarized where possible, at the request of the Virginia Department of Health.

1. Our Security Department has adequate training to handle large crowds coming to our facility for these events.

The overall rating for this question was in the neutral range. Several hospitals in the Central, East, Northwest and Southwest 1 regions rated this question in the disagree range indicating the need for more training on crowd control for these hospitals.

2. Our Department is adequately prepared for decontamination (BCNE are listed).

The overall rating for this question was in the neutral range with greater agreement of being prepared for decontamination of chemical events. Some hospitals in all regions indicated the need for more training in biological, chemical, nuclear/radiological, and explosive events. The East and Northwest regions had a noticeable number of disagree ratings for nuclear/radiological and explosive events indicating the need for training.

3. Our Department has adequate personal protection training to protect us personally from (BCNE are listed).

The overall rating for this question was in the neutral range with the exception of biological events that had a median score in the disagree range indicating a need for training in personal protection. Several hospitals in the Central, East, Northwest, and Southwest regions indicated disagreement; therefore, this suggests the need for personal protection training in all categories of biological, chemical, nuclear/radiological, and explosive events.

4. Our Department has readily available information on hazardous materials and how to use these resources for (BCNE are listed).

There was general agreement on all categories in this question. However, there were some hospitals in all regions that selected disagree or neutral on this question indicating that this information is not readily available in all hospitals in the study. The category that received the largest number of disagree and neutral ratings was nuclear/radiological information.

5. Safety/security and fire/rescue personnel are completely aware of their specific responsibilities (division of labor) in (BCNE are listed).

The overall rating for this question was in the agree range with the responsibilities for nuclear/radiological events being less clear. There were some hospitals in the Central, East, Southwest 1, and Southwest 2 regions that consistently rated all

BCNE events in a disagree or neutral category indicating that some hospitals in these regions do not have clearly defined divisions of labor.

6. Our Department has been trained on how to preserve the scene for evidence for (BCNE are listed).

The overall rating of this question was in the neutral category for all events except nuclear/radiological events that had a rating in the disagree category. All regions had hospitals that had ratings in the disagree category for all events, however, the Northwest region consistently had the majority of the reporting hospitals in the disagree category indicating the need for training in this area.

7. Our Department has been trained in the concept of incident command for (BCNE are listed).

All events except nuclear/radiological had overall ratings in the agree category. Nuclear/radiological events had a median rating that was in the neutral category. All regions had some disagree selections. The East, Northwest, and Southwest 1 regions had a consistent number of disagree categories for all events. The majority of Southwest 1 hospitals participating in this study rated all events in the disagree category indicating a need for training.

8. Our Department is aware of specific techniques to make our facility less vulnerable to (BCNE are listed).

The overall ratings for biological and chemical events was in the agree range, and for nuclear/radiological events in the neutral range. The Northwest and Southwest 1 regions hospitals had a greater tendency than other region hospitals to have more ratings in the disagree categories for all events indicating a need for training.

9. Our Department has performed a risk assessment for (BCNE are listed).

The overall rating for all events was in the agree category. The North, East, and Northwest regions had one hospital each rating all events in a disagree category but the majority of all reporting hospitals was in the agree category.

10. Our Department has participated in statewide emergency preparedness drills.

There was widespread general agreement with this question in all regions.

Summary of Perception of Emergency Preparedness and Response (Questions 1-10)

There is always a need for caution in the interpretation of this data since not all Virginia hospitals participated in this study. Because of the small number of responding hospitals by region, it is difficult to generalize these findings to all hospitals located in a specific region. In addition, for-profit hospitals are under-represented in the sample. However, these data suggest that there is some agreement on training needs, although within each region there were variances among hospitals, some perceiving more needs for training than others.

Questions 1,2, 3 and 6 had average ratings in the neutral range indicating that a number of hospitals had need for training in these areas. Within the reporting of

each question, regional differences are described. The responses to question 4 indicated that some hospitals need more readily available information on hazardous materials, and how to use these resources for events, and a number of hospitals wanted more information on nuclear/radiological events. The participants from the East, Northwest, and Southwest 1 regions expressed concerns about training for incident command (Question 7).

Thus, there is indication of training needs in the areas of: large crowd control, decontamination procedures, personal protection training, need for nuclear/radiological information and it's used, how to preserve the scene for evidence, incident command in some regions of the state, and how to make a facility less vulnerable to nuclear/radiological events.

Perception of Training Experiences and Needs Questions 11-21)

Questions 11-16 were multiple-choice questions, and 17-21 were open-ended requiring a written response. Responses are based only on surveys with an identified region.

11. Our strongest need for training is in the area(s) (more than one category could be selected on this question.)

North Region	**Number (Percentage)**
a. Specific information	3 (33.3 %)
b. Planning	0 (0 %)
c. Incident command	1 (11.1%)
d. Drill coordination	2 (22.2%)
e. Decon equipment	2 (22.2%)
f. Other:	1 (11.1%)

Personal Protection Equipment

Central Region	**Number (Percentage)**
a. Specific information	1 (11.1 %)
b. Planning	1 (11.1 %)
c. Incident command	1 (11.1 %)
d. Drill coordination	2 (22.2 %)
e. Decon equipment	2 (22.2 %)
f. Other:	2 (22.2 %)

Response and recovery techniques for WMD incidents
PPE/COBRA

East Region	**Number (Percentage)**
a. Specific information	4 (26.7 %)
b. Planning	2 (13.3%)
c. Incident command	3 (20 %)
d. Drill coordination	1 (6.7 %)
e. Decon equipment	4 (26.7 %)
f. Other:	1 (6.67 %)

Security specific training for individuals who may serve in some security capacity

Northwest Region	**Number (Percentage)**
a. Specific information	1 (8.3 %)
b. Planning	4 (33.3 %)
c. Incident command	2 (16.6 %)
d. Drill coordination	2 (16.6 %)
e. Decon equipment	3 (25 %)
f. Other:	0 (0 %)

Southwest 1 Region	**Number (Percentage)**
a. Specific information	3 (21.4 %)
b. Planning	1 (7.1 %)
c. Incident command	4 (28.6 %)
d. Drill coordination	2 (14.3 %)
e. Decon equipment	4 (28.6 %)
f. Other:	0 (0 %)

Southwest 2 Region	**Number (Percentage)**
a. Specific information	2 (28.5 %)
g. Planning	1 (14.3 %)
h. Incident command	0 (0 %)
i. Drill coordination	1 (14.3 %)
j. Decon equipment	3 (42.9 %)
k. Other:	0 (0 %)

12. What method of training do you most prefer?

North Region	**Number (Percentage)**
a. Classroom setting	3 (100%)
b. CD roms for self-paced	0 (0%)
c. Web-based methods	0 (0%)
d. other	0 (0%)
(2 no response)	

Central Region	**Number (Percentage)**
a. Classroom setting	2 (66.7%)
b. CD roms for self-paced	0 (0%)
c. Web-based methods	0 (0%)
d. other	1 (33.3%)
VCR tapes, books and manuals	

East Region	**Number (Percentage)**
a. Classroom setting	4(80%)
b. CD roms for self-paced	1 (20%)
c. Web-based methods	0 (0%)
d. other	0 (0%)
(3 no response)	

Northwest Region	**Number (Percentage)**
a. Classroom setting	4(100%)
b. CD roms for self-paced	0 (0%)
c. Web-based methods	0 (0%)
d. other	0 (0%)
(3 no response)	

Southwest 1 Region	**Number (Percentage)**
a. Classroom setting	4(80%)
b. CD roms for self-paced	1 (20%)
c. Web-based methods	0 (0%)
d. other	0 (0%)
(2 no response)	

Southwest 2 Region	**Number (Percentage)**
a. Classroom setting	3 (100%)
b. CD roms for self-paced	0 (20%)
c. Web-based methods	0 (0%)
d. other	0 (0%)

13. If classroom training is used, what is your preferred location?

North Region	**Number (Percentage)**
a. in my locality	2 (40%)
b. travel to another facility	0 (0%)
c. at our facility	3 (60%)

Central Region	**Number (Percentage)**
a. in my locality	2 (100%)
b. travel to another facility	0 (0%)
c. at our facility	0 (0%)
(1 no response)	

East Region	**Number (Percentage)**
a. in my locality	2 (25%)
b. travel to another facility	0 (0%)
c. at our facility	6 (75%)

Northwest Region	**Number (Percentage)**
a. in my locality	3 (60%)
b. travel to another facility	0 (0%)
c. at our facility	2 (40%)
(2 no response)	

Southwest 1 Region	**Number (Percentage)**
a. in my locality	3 (50%)
b. travel to another facility	1 (16.7%)
c. at our facility	2 (33.3%)
(1 no response)	

Southwest 2 Region	**Number (Percentage)**
a. in my locality	3 (100%)
b. travel to another facility	0 (0%)
c. at our facility	0 (0%)

14. What is your Department's preferred length of time for traditional classroom Training?

North Region	**Number (Percentage)**
a. one hour	1 (20%)
b. 3 hours	3 (60%)
c. 4 hours	0 (0 %)
d. 8 hours	1 (20%)
e. 1-2 days	0 (0%)

Central Region	**Number (Percentage)**
a. one hour	0 (0%)
b. 3 hours	1 (33.3%)
c. 4 hours	2 (66.7 %)
d. 8 hours	0 (0%)
e. 1-2 days	0 (0%)

East Region	**Number (Percentage)**
a. one hour	3 (37.5%)
b. 3 hours	1 (12.5%)
c. 4 hours	1 (12.5%)
d. 8 hours	3 (37.5%)
e. 1-2 days	0 (0%)

Northwest Region	**Number (Percentage)**
a. one hour	1 (20%)
b. 3 hours	0 (0%)
c. 4 hours	1 (20 %)
d. 8 hours	2 (40%)
e. 1-2 days	1 (20%)
(2 no response)	

Southwest 1 Region	**Number (Percentage)**
a. one hour	1 (14.3%)
b. 3 hours	1 (14.3%)
c. 4 hours	1 (14.3 %)
d. 8 hours	4 (57.1%)
e. 1-2 days	0 (0%)

Southwest 2 Region	**Number (Percentage)**
a. one hour	1 (33.3%)
b. 3 hours	0 (0%)
c. 4 hours	1 (33.3 %)
d. 8 hours	1 (33.3%)
e. 1-2 days	0 (0%)

15. How many times a year would your facility be able to allow attendance at classroom training?

North Region	**Number (Percentage)**
a. one time	0 (0%)
b. two times	2 (66.7%)
c. three times	0 (0%)
d. four times	1 (33.3%)
e. more than four times	0 (0%)
(2 no response)	

Central Region	**Number (Percentage)**
a. one time	0 (0%)
b. two times	1 (33.3%)
c. three times	0 (0%)
d. four times	0 (0%)
e. more than four times	2 (66.7%)

East Region	**Number (Percentage)**
a. one time	0 (0%)
b. two times	3 (37.5%)
c. three times	1 (12.5%)
d. four times	4 (50%)
e. more than four times	0 (0%)

Northwest Region	**Number (Percentage)**
a. one time	0 (0%)
b. two times	1 (14.3%)
c. three times	1 (14.3%)
d. four times	1 (14.3%)
e. more than four times	3 (42.9%)
(1 no response)	

Southwest 1 Region	**Number (Percentage)**
a. one time	0 (0%)
b. two times	5 (71.4%)
c. three times	1 (14.3%)
d. four times	0 (%)
e. more than four times	1 (14.3%)

Southwest 2 Region	**Number (Percentage)**
a. one time	0 (0%)
b. two times	2 (66.7%)
c. three times	0 (0%)
d. four times	1 (33.3%)
e. more than four times	0 (0%)

16. Is receiving continuing education units (CEUs) important in this training?

North Region	**Number (Percentage)**
a. yes	0 (0%)
b. no	5 (100%)

Central Region	**Number (Percentage)**
a. yes	0 (0%)
b. no	3 (100%)

East Region	**Number (Percentage)**
a. yes	3 (37.5%)
b. no	5 (62.5%)

Northwest Region	**Number (Percentage)**
a. yes	2 (33.3%)
b. no	4 (66.7%)
(1 no response)	

Southwest 1 Region	**Number (Percentage)**
a. yes	4 (57.1%)
b. no	3 (42.9%)

Southwest 2 Region	**Number (Percentage)**
a. yes	3 (100%)
b. no	0 (0%)

Summary of Questions 11-16.

The areas of needed training that were repeated in all regions were: specific information (knowledge of specific agents and control techniques), incident command (all but Southwest 2), drill coordination, decontamination techniques, and the Northwest Region showed a stronger interest in planning training. It should be noted that decontamination training was the most frequently cited training need reported by all respondents.

Most respondents prefer a classroom setting with hands on training in their facility or locality.

The preferred length of training varied from one-half day (3-4 hours) to a full day (8 hours). Our focus group participants often mentioned that the length of the class depended upon the material but that they do prefer hands on training where there is a combination of information and practice.

The most frequently selected time that they could get away for training was two times a year, but some could manage to get away four times a year.

Some regions appeared to have no interest in CEUs and others had mixed opinions. A majority (58.8%) of the respondents (all regions combined) indicated that CEUs were not important. This issue would need to be clarified in each locality before the training is offered.

17. Please list the specific emergency preparedness training that you would like the Virginia Department of Health to develop.

The following are the summarized results from all regions. The individual summaries of each region can be found in Appendix J. There were no glaring differences in recommendations for the regions except that more rural areas would like planners to consider the needs of rural hospitals.

Communication at all levels, e.g.
- Communication procedures between local agencies, hospitals, and within a hospital
- Incident response command communication
- Coordinated information to public, media, EMS, and hospitals (Everyone is saying the same thing).
- Establish a command center with a hospital reporting function and coordination of the sharing of hospital resources if an event occurs

Virginia Department of Health would have a coordination function: e.g.
- Regional training centers that develop community training and coordination with media, public, EMS, and hospitals
- Helping assess priorities

Providing on-site training at no cost
- Develop a listing of training programs by appropriate professional organizations and utilize some of these organizations' train the trainer programs
- Work with VHHA to have administrators buy into non-clinical staff development
- Coordinate training with other Virginia agencies such as MMRS and HRSS
- Coordinate information between all regions so that everyone has the same information and procedures
- Develop policies and procedures for healthcare workers in both clinical and non-clinical areas

Specific information e.g.
- How do first responders and hospital workers respond to biochemical events
- Knowledge of specific chemical, biochemical, and radiological agents and control techniques
- Personal Protection Equipment training
- Crime scene preservation
- Improvised explosive devices (IED) identification and training for explosive events
- Response and recovery from weapons of mass destruction (WMD) and security of hospital with these
- Decontamination procedures for nursing, housekeeping, emergency department, and security
- How to deal with large crowds of concerned and/or contaminated people

18. In the past 12 months, what training has your Department received and who provided it?

The following are the summarized results from all regions. The individual summaries of each region can be found in Appendix J.

Examples of training included decontamination, personal protection equipment, crisis management, various drills, HAZMAT, bomb threats, information on weapons of mass destructions and examples of specific training such as ASP Baton and OC Spray/Handcuffing. Most of the training was by in-house personnel or outside consultants and the amount of training time varied from one to 40 hours. Many had participated in drills conduction by the Virginia Department of Health.

19. Please rate the effectiveness of any training services/activities that you have attended by the Virginia Department of Health on a scale of 1-5 where 1 is excellent and 5 is poor.

The following are the summarized results from all regions. The individual summaries of each region can be found in Appendix J.

Examples of training received from the Virginia Department of Health were webcasts for smallpox and state emergency preparation plan, the Statewide Drill in October 2003, weapons of mass destruction, incident command, and biohazards. The ratings ranged from 1 to 3 with the majority of the ratings being 2 or 3 that would put the rating in an average to very good range.

20. What print or web sources have you found were helpful for information on biological, chemical, nuclear, radiological, and explosive events?

The following are the summarized results from all regions. The individual summaries of each region can be found in Appendix J.

Frequently cited web sources were U. S. Army, Homeland Security, FBI, CDC, ASIS, DOD, TSA, VA Department of Emergency Management, Federal Emergency Administration, Twotigers, Hazmat for Healthcare, VA Department of Emergency Preparedness, Firehouse, U. S. Post Office, and APIC.

Useful print resources cited were Weekly Homeland Security Newsletter, Community Medical Disaster Planning and Evaluation Guide published by American College of Emergency Physicians, and Preparing for Mass-Casualty Incidents by Steven A. MacArthur.

21. What 3 actions should the Virginia Department of Health take in order to improve emergency preparedness within the Commonwealth?

The following are the summarized results from all regions. The individual summaries of each region can be found in Appendix J.

- Provide central communication and coordination of emergency preparedness activities, e.g.
  - Provide up to date information and improve communications with and among all entities, fire, rescue, hospitals, media, public, municipal governments, and VDH so that everyone is saying the same thing.
  - Have joint trainings and drills of fire, police, rescue, and hospital personnel to facilitate cooperation
  - Institute periodic information briefings
  - Standardize emergency codes for all hospitals
  - Initiate and facilitate local emergency response command committees (LERC)

- Mandate certain trainings such as immediate decontamination and PPE training for police and hospital security personnel, lockdown capabilities, and hiring trained security personnel.
- Standardize what the PPE package should be for hospitals
- Establish a Command Center with hospital reporting function
- Develop surge capacity for hospitals and pooling of resources within and between regions
- Develop simple templates/guidelines/procedures that all VDH regions will follow
- Develop a robust matrix with a clear command structure of who to call and what are the first steps in different situations
- Develop survey assessment instruments
- Coordinate statewide, district, and community plans.
- Develop specific guidelines for reporting and handling all emergencies

Provide on-going training, e.g.

- Be the central clearinghouse for valid training programs, develop community training programs, and publicize specific trainings.
- Develop train the trainer programs
- Utilize valid existing professional organizations training programs
  - Crowd control for large numbers of concerned and/or contaminated persons
- Adapt training to rural areas
- Adapt training to different department responsibilities such as Emergency Department and security
- Produce simple/concise brochure for Emergency Department personnel on first response and triage for biological/chemical event, victim characteristics, list of agencies and contact persons.
- Decontamination and PPE
- Provide hospitals with a standard PPE package

Provide funding, e.g.

- On-site training programs
- Provide grant money for non-clinical functions related to chemical, biological, radiological, and explosive events
- Publicize funding available for training and salaries
- Fund emergency planner position in hospitals
- Provide greater resources to facilities that are in rural areas because they are miles apart.

General Questions: We would also appreciate your input to the following general questions:

22. Do we need to have standard emergency codes) e.g. all numbers and colors mean the same thing) for all hospitals in Virginia?

This question had the following results: 26 (76.5%) Yes, 6 (17.6%) No, and 2 (5.9%) did not answer. All regions had more votes for standardization, and all regions except Southwest 2 had at least one no response. Overall, a majority of respondents (76.5%) favored the standardization of emergency codes.

23. The Virginia Department of Health should take a leadership role in developing and providing training on emergency preparedness for hospitals and health care providers. (This question had the likert strongly agree to strongly disagree scale used on questions 1-10)

The average response for all regions was between agree and strongly agree. All regions except the Northwest region had all responses in the agree and strongly agree categories. There was one Northwest region respondent who chose neutral. Thus, this data strongly indicates the expectation that the Virginia Department of Health should take a leadership role in developing and providing training on emergency preparedness for hospitals and health care providers.

24. If CEUs are important in emergency preparedness training, what organizations should be approached?

The following were suggested: Virginia Department of Emergency Management Services, the Virginia state institutions of higher learning, Virginia Department of Criminal Justice, nursing and physician organizations, state organizations, Virginia Department of Health, Virginia Board of Nursing, ENA, ACEP, and Virginia EMS.

25. Would you be willing to participate in a local volunteer Medical Reserve Corps?

The responses were 16 (51.6%) yes, 10 (32.2%) no, 5 (16.1%) undecided and 3 no responses. There were yes and no responses in all regions.

Some of the comments were:

that they are not physicians, and some had been EMTs but had not taken refresher courses and no longer were certified.

they currently have demanding responsibilities and could not be available.

many people wanted more details about the program.

26. What suggestions do you have for Virginia in its efforts to develop and implement the Medical Reserve Corps in Virginia?

The following suggestions were offered:

Publicize the program with mass advertising campaign of duties and responsibilities

Use existing Fire/EMS people and examine establishing recertification programs for EMTs who have elapsed certifications

Meetings of professional groups could be used for recruitment
Recruit college students including medical students and residents
Use military reservists
Use private home health agencies
Keep the MRC as local as possible so they can participate
Coordinate well with the command hospital
Healthcare personnel will be on the job anyway. Therefore, need to recruit and train with a certification program other members of the community
Offer financial incentives such as free license renewal, and free CEUs to those who need them

III. Infectious Disease Coordinators in Community, Acute Care Hospitals and Specialty Hospitals

Six focus groups were conducted with Coordinators of Infectious Disease Control in Virginia's general, acute care, community hospitals and specialty hospitals. One focus group was conducted in each of the six State Hospital Planning Regions and a meal and $50 premium was provided each participant. The locations were Abingdon, Richmond, Virginia Beach, Roanoke, Arlington (Crystal City), and Harrisonburg.

The Virginia Chapter of the Association for Professionals in Infection Control and Epidemiology, Inc was very helpful in sharing their membership lists. In addition, the Virginia Regional Epidemiologists were contacted and shared a listing of infection control coordinators in their region. These lists were used to randomly select participants, who were then contacted by telephone. In addition, a reservation form and poster were faxed to the hospitals that were by phone contacted. Telephone contact proved to be the most effective method to recruit participants.

Focus group questions (Appendix B) were developed and reviewed by the James Madison University IRB and the Virginia Department of Health. The goals of the project and confidentiality precaution procedures were explained to the participants, and they signed a James Madison University IRB approved consent form (Appendix C) prior to the beginning of the focus group discussions.

Results of Infectious Disease Coordinators Focus Group

The results of the six Focus Groups for Infectious Disease Coordinators suggest similarities as well as differences in their views and perceptions concerning emergency preparedness in Virginia. Their views and opinions are very important, as these providers serve as one of the first points of contact and consultation in hospitals regarding emergency preparedness and response. This section summarizes the Focus Group findings for all regions of the state. Individual results by Focus Group are presented in Appendices D-I.

1. Role of Virginia Department of Health (VDH) in Emergency Preparedness and Response

Participants were quick to point out the role of VDH in emergency preparedness and response. In several groups, participants acknowledged that the role of the Department of Health has changed since 9/11 and that VDH is currently adapting to their new role in a period of rapid growth and change. The general views of the roles of VDH are as follows:

Provide leadership throughout the state in preparing for and responding to emergency events. VDH should have major leadership role in preparedness and response and assume a command function.

Provide information and education to hospitals and direct care providers on how to respond. Facilitating recognition of events, and appropriate response, is seen by participants as critical.

Provide effective communications both within VDH and the local Health Departments (HDs) as well as between HDs, hospitals and local providers. This communication refers to notice of alerts and events, coordination of action steps and follow-up, and responses by VDH to inquiries and perceived events expressed by providers.

Provide effective distribution of resources (manpower, vaccines/medications and equipment) to assist local providers in times of need

Disseminate information to the general public, and educate the public on how to prepare and how to engage in appropriate behavior in times of an emergency

Work with the media to ensure accurate and timely reporting of events, actions taken by VDH and appropriate public behavior.

Develop effective Emergency Preparedness plan for the state and implement it. It was noted that roles of VDH and respective local providers are not clear in times of an emergency (who, specifically, does what).

Assess and communicate needs(e.g., status of hospital surge capacity and equipment) and develop training programs to address those needs

Show interest and advocacy for the state (given that perceived interest in and support for Emergency Preparedness issues have declined somewhat since 9/11)

Understand the role of and work demands placed on Infectious Disease Coordinators and develop a realistic appraisal of expectations for hospitals to provide information/data in short turnaround.

2. Concerns with the Public Health System

The most reported concern is the deficiency in communication between local and state levels of VDH, and variation of communication between VDH, local HDs and providers (Five of six regions noted this). Several examples provided by participants illustrated this (e.g., results of table-top exercises, variation in who received Fax Blasts from VDH, and poor follow-up by VDH to requests for assistance). Many participants pointed out that there is variation within local areas in terms of who gets what information, and that it is sometimes based on working relationships that have been developed between hospital personnel and VDH staff rather than all providers receiving needed information. Some participants pointed out that better communication is occurring between VDH and hospitals in last year or so, and that drills and increasing efforts by VDH and hospitals at establishing relationships were noted as positive efforts. Several expressed favorable views of efforts VDH is taking. Reported examples of this included the fact that VDH staff comes to Infectious Disease Coordinator meetings in several regions, and VDH sponsorship of the Epidemiology Forums.

Role of non-hospital organizations (primary care physicians, clinics and long term care organizations, etc.,) needs to be recognized by VDH and greater effort placed on involving them in communications and response.

Need for guidance from VDH on Best Practices/ Recipes/ checklists for hospital personnel quick response in emergency events.

3. Means to Contact/Access Public Health System

Participants from across the state indicated their specific knowledge of how to contact public health staff in times of an emergency. The recent actions taken by VDH in providing staff contact names and telephone numbers, cell telephone phone numbers, beeper numbers, etc., to hospital personnel were cited and viewed by participants as very helpful. However, there was some confusion indicated as to when to use the state level 24/7 back-up telephone number.

4. Experience with Contacting Public Health System in the Past

Participants reported that in the past requests for assistance have been met largely with success. However, there were several instances described by participants that indicated unfavorable responses and or difficulties in gaining access to VDH staff in times of urgent need in the past. The specific reasons why these difficulties occurred are unclear.

5. Involvement with Emergency Preparedness and Readiness Planning

Participants noted that they have received a significant amount of training in the past with regard to emergency preparedness and readiness, particularly in the area of bioterrorism. This training has come largely from local hospitals, healthcare associations and professional groups. While some training has come from VDH, participants noted that the

vast majority has come from these other sources. Some focus group participants identified VDH as the sponsor of some training while other individuals expressed confusion as the sponsorship of training. Several participants noted that they expect VDH to sponsor more training in the future.

6. Training Needs

Clarification of actions to be taken by VDH staff and local providers (strategic coordination)

Chemical and radiological preparedness training)

Basics of how to respond effectively to different types of events (recognition and response, use of PPE, what to do and not to do for specific events))

VDH should provide updates/time-stamped information on emerging problems (SARs, monkeypox) as well as updates on bioterrorism to assist providers

Standard protocol process for all providers across the state in responding to events

PPE for specific events and "fit-testing" of this equipment

Sterilization and decontamination issues: how to handle contaminated individuals, equipment and facilities, and how to quarantine a facility (and who has authority to quarantine a facility?)

7. Methods of Training

Combinations of training were suggested: classroom, send experts out to hospital sites, and computer/web-based systems (web-sites, web casts, CD Roms). However, in all six regions participants indicated classroom training was preferred or acceptable.

VDH should be lead in identifying the training courses that are available within the Commonwealth and make sure that providers know that these exist and can take advantage of them.

Classroom training/on-site training must be evidence based and provided by experts in those content areas.

Length of preferred training should vary by the topic addressed.

Web-based systems should be more than just "reading," and should include testing for competencies in various knowledge areas

Value of CD Roms was mixed: Use of CD-Roms was seen as helpful in two groups and unhelpful in two groups, not mentioned in two groups. One group suggested that CD-

Roms need to be kept to an hour or less to facilitate viewing. Several participants indicated that CD-Roms could be used in conjunction with classroom training.

The importance of CEUs was reported as mixed: one-half of the groups viewed CEUs as NOT important

If CEUs are deemed important, work with professional groups to award the CEUs as there are no requirements for nurses to do this

8. Medical Reserve Corps (MRC)

In general, there was widespread lack of knowledge concerning this effort. Typically, only one or two participants in each group expressed awareness of the MRC effort being undertaken in Virginia. Once the concept was clarified by the facilitator, most individuals felt that their first responsibility was to their respective hospitals, but expressed that they would be open to serving other areas around the state if the need arose. Many individuals stated that they thought the form they were required to complete when they renewed their nursing license was indicative of their volunteering for MRC (this was a major point of confusion for many participants).

9. Suggestions for State in Developing/Implementing MRC

Clarify expectations of state for providers

Clarify liability issues

Define tour of duty such as in military reserves with protection of jobs after serving

Publicize it more: If Infectious Disease Coordinators have not heard about MRC, participants stated that MRC should be communicated/publicized more.

Focus on competencies, experience levels, licensure and credentials for volunteers (want latest, up to date skills (three regions)

Coordinate with local Incident Command Centers at each hospital

Recognize fear factor—a lot of individuals may NOT volunteer due to not wanting to expose their families; recruitment efforts should acknowledge this (two regions)

Once you have list of volunteers, how to get hold of them in an emergency situation

Physicians need to have inter-hospital privileges to make the MRC work

Concern was expressed that MRC efforts should not detract from VDH efforts for education and training of states' providers

IV. Hospital Emergency Department Physicians, Nurses Personnel

Three focus groups were conducted with emergency room physicians in Abingdon, Richmond, and Virginia Beach. The three emergency room nurses groups were in Roanoke, Arlington (Crystal City), and Harrisonburg. All focus group participants received a meal and a $100 premium was offered to physicians and $50 to nurses.

The following organizations were contacted to assist in recruiting emergency department physicians and nurses: Association of Emergency Physicians, American College of Emergency Physicians, Emergency Nurses Associations and the Virginia Chapter of the Emergency Nurses Association. The Virginia Emergency Nurses Association was very helpful in providing email addresses of their members. When available, email addresses were used to send a recruitment poster and reservation form. However, there was very little response to email, and the most effective technique was to call individual emergency departments and talk to the director or the nurse manager. This conversation was then followed up with a fax of the recruitment poster and reservation form, and emailed information.

Focus group questions (Appendix B) were developed and reviewed by the James Madison University IRB and the Virginia Department of Health. The goals of the project and confidentiality precaution procedures were explained to the participants, and they signed a James Madison University IRB approved consent form (Appendix C) prior to the beginning of the focus group discussions.

Emergency Department Nurses – Summary of Focus Groups

The results of the three Focus Groups for Emergency Department Nurses suggest similarities as well as differences in their views and perceptions concerning emergency preparedness in Virginia. Their views and opinions are very important, as these providers serve as one of the first points of evaluation and treatment for individuals exposed to biological, chemical and radiological agents. This section summarizes the Focus Group findings for three regions of the state. Individual results by Focus Group are presented in Appendices K-M

1. Role of Virginia Department of Health (VDH) in Emergency Preparedness and Response

Participants were quick to point out the role of VDH in emergency preparedness and response. The general views of the roles of VDH are as follows:

> Provide leadership throughout the state in promoting awareness and sharing information with providers; portray a positive vision to providers and public that "we can get through this." Be visible to local providers, and involved in local preparedness activities.

Provide coordinated training of healthcare providers, including providing effective algorithms on treatment of biological and chemical agents and information and education to hospital emergency room staff on how to respond effectively, based on understanding research and "Best practices."

Develop effective communications systems within VDH and have key contacts identified at local and state levels that communicate with the "right" person (Medical Director) at the hospital level.

Provide effective planning for manpower and resources to come to areas if event occurs.

Disseminate information to the general public, and educate the public on appropriate action in times of an emergency.

Clarify roles relative to VDH and hospitals: there seems to be different "cultures" and there is a need to clarify respective roles in response to an "event."

Coordinate with local Fire and Rescue.

Educate the private practice physician on symptom recognition and appropriate Response.

Coordinate lab services that VDH provides to ensure proper diagnoses. Establish evaluation mechanisms for post-event reviews.

VDH has moved to more closely integrate activities with local providers and has accomplished quite a lot.

2. Concerns with the Public Health System

The most reported concerns are threefold: 1) limited training that is being provided; 2) limited coordination of local emergency preparedness and response efforts of hospitals; and 3) concerns about adequacy of manpower to effectively mount a coordinated effort in times of an event. In addition, participants pointed out the lack of clarity on the roles of VDH and hospitals in response to an event, raised the lack of 24/7 availability of and access to public health staff, and questioned the level of support for local jurisdictions given regionalization efforts of VDH. Also, the role of media has raised the issue of having a central source/location for information dissemination from VDH to the local media. Preparing the public and local schools were also mentioned as important concerns.

3. Means to Contact/Access Public Health System

Participants from across the state indicated their specific knowledge of how to contact public health staff in times of an emergency. Participants reported that VDH has provided staff contact names and telephone numbers to increase access. Participants in one region mentioned that "flip cards/charts" with VDH contacts/numbers have been established within the Emergency Rooms to provide quick access for Emergency Room staff. Participants in one region mentioned that alot of numbers had to be called sometimes to access someone.

4. Experience with Contacting Public Health System in the Past

Several participants reported that in the past requests for assistance have been met largely with success. These included a reported case of TB, two anthrax cases and one possible SARS case.

5. Involvement with Emergency Preparedness and Readiness Planning

Participants noted that they have received varying amounts of training in the past with regard to emergency preparedness and readiness. In one region, some participants reported having had HAZMAT training but lacked training on planning and coordinating a response, while in two regions participants reported that they have had some training in biological and general emergency preparedness. This training has come largely from local hospitals, EMS organizations and other professional groups. Some participants in one region stated that they received on-going "training" from e-mailed notification of events and recommended approaches to treat.

6. Training Needs

Best approaches on recognizing signs and symptoms for biological and chemical agents, understanding process for triage and quarantine, decontamination and containment.

Clarification of coordinating actions to be taken by multiple Emergency Rooms in responding to an event.

Radiological preparedness training and controls.

Availability of pharmaceuticals and adequacy of stockpiles.

Surge capacity issues.

VDH should conduct a site survey on assessing hospital equipment needs and identify vendors to help in getting best "bulk buys" for hospitals.

Use of standardized protocols so that everyone is giving out same information in all hospitals.

Training should be planned and offered in recognition of what is being provided under HRSA grants that some areas have been given.

7. Methods of Training

Combinations of training were suggested: classroom and computer/web-based systems (web-sites, web casts, CD Roms). One region only endorsed classroom training and viewed CD-Roms and other methods of training as helping to reinforce classroom training, while two other regions felt classroom training would be ok or not be that useful given the demand on ER staff and suggested alternative education methods

The importance of CEUs was reported as mixed: one group saw CEUs as unimportant, while two other groups viewed CEUs as important in motivating Emergency Room staff to complete training. The group seeing CEUs as unimportant felt that CEUs would only become important if they became mandated for licensure.

Resources and web sites found helpful were reported by participants as: VHHA, APIC, CDC, Emergency Nurses association, Florida Board of Nursing, and the Virginia Department of Emergency Management (take courses on-line).

8. Medical Reserve Corps (MRC)

In general, there was widespread lack of knowledge among ER nurses concerning this effort. When questioned about MRC, usually no one responded. Once the concept was clarified by the facilitator, most individuals felt that their first responsibility was to their respective hospitals, but expressed that they would be open to serving other areas around the state if the need arose. Many individuals stated that they thought the form they were required to complete when they renewed their nursing license was indicative of their volunteering for MRC (this was a major point of confusion for many participants).

9. Suggestions for State in Developing/Implementing MRC

Consider whether hospitals will let staff off to do this work

Clarify expectations of the state for staffing of MRCs

Let hospitals know what the expectations are for them in using volunteers

Look to examples of other states as to how they have done volunteer corps

Hospitals should be in role of clearinghouse function for MRCs given their role as a central resource for screening and treatment in an emergency event. Focus on scope of responsibility, competencies/skill levels, credentials and training for volunteers

Coordinate with Department of Professional Regulation to carry out credentialing

Eliminate liability for volunteers under the "Good Samaritan" laws

Recognize that volunteers have concerns about the safety and security of their own families, and that this may limit volunteers' availability in times of need

Consider child daycare for parents to free parents up for volunteering

Use of MRC relative to surge capacity issues and quarantine

Provide incentives such as providing training that allows people to move up a level in their responsibility

Emergency Department Physicians – Summary of Focus Groups

The results of the three Focus Groups for Emergency Department Physicians suggest similarities as well as differences in their views and perceptions concerning emergency preparedness in Virginia. This section summarizes the Focus Group findings for three regions of the state. Individual results by Focus Group are presented in Appendices N-P

1. Role of Virginia Department of Health (VDH) in Emergency Preparedness and Response

The general views of the roles of VDH are as follows:

> Providing leadership throughout the state in Emergency Preparedness and Readiness, and providing accurate and timely information in tines of an event
>
> Provide training and education of healthcare providers: recognition and treatment of emergency events, and summary information that "distills" best practices in terms of recognition and treatment
>
> Identify local "agents" and establish proper methods of prophylaxis and quarantine
>
> Providing effective communications among health department staff, CDC and local hospitals

Disseminate information to the general public, and educate and communicate with the public to create positive public expectations and appropriate action in times of an emergency

Educate the private practice physician on emergency preparedness and response

Manage volunteers (ancillary staff, and establish a rapid credentialing process)

Develop a plan for distribution of medications and equipment to hospitals, and assist hospitals in purchase of equipment needed by hospitals (Decon, PPE, etc.)

Coordinate media messages to public and medical community

Be available and on-call during an actual event

Identify key VDH staff that hospital ED staff are to contact

2. Concerns with the Public Health System

The most reported concerns are fourfold: 1) limited or lack of awareness as to what the state is doing/training that is being provided; 2) limited coordination of services among local hospitals; 3) the perception that hospitals seem to be "on their own" with regard to preparation and response, and state has not addressed surge capacity issue; and 4) hospitals are concerned about having the tools (vaccines, equipment, etc.) to do the job adequately, and are concerned about distribution of medications and supplies. One region felt that their training needs were being ignored. There was a split in terms of perceptions of progress being made: two regions felt that VDH assistance was not adequate, and one region felt that considerable progress had been made and improvement in coordination between public health and hospitals had increased dramatically. Also, concerns were expressed about adequacy of VDH manpower to effectively mount a coordinated effort. In addition, it was noted that geographic access for some physicians due to the rural nature of the area may limit response in an emergency.

3. Means to Contact/Access Public Health System

Participants from across the state indicated their specific knowledge of how to contact public health staff in times of an emergency. Participants reported that VDH has provided staff contact names and telephone numbers to increase access. Participants in one region questioned what would be done if phones could not be used, and suggested that specially trained hospital individuals be designated perhaps using radios and or ham radio operators.

4. Experience with Contacting Public Health System in the Past

Several participants reported that in the past requests for assistance have been met largely with success, although a few stated that access to VDH has been poor. These prior instances included a possible case of anthrax; others included rabies incidents (3), West Nile, influenza, and hepatitis. Two participants stated that night assistance from VDH seemed "lagged."

5. Involvement with Emergency Preparedness and Readiness Planning

Participants noted that they have received varying amounts of training in the past with regard to emergency preparedness and readiness. Usually, this training has been provided at the hospital level using experts that have been brought in to individual hospitals or to a hospital system. In the rural region, there has been little in teems of emergency preparedness planning training provided. Participants in two regions noted that VDH has not provided any training to their knowledge.

6. Training Needs

Best approaches on recognizing signs and symptoms for chemical and radiological exposure, understanding process for triage, ED lock-down, and quarantine, decontamination and containment, and risk assessment of patients to protect personnel providing treatment

Incident command response—identifying responsibilities at different facility levels and identifying who is in charge at each level

Managing proper dosages of antibiotics and vaccines for children (very different than adults and implications for educating adults on rationale for what is used)

Have inventory of resources available for training (it was noted that local emergency coalitions will be doing training for all hospitals, and therefore, VDH training must be coordinated with groups like this)

Reporting systems for planning and evaluating disaster events

Dealing with surge capacity issues and alternate care sites

Training on identifying the resources of VDH for use on-site in the event of an emergency; it was noted that there should be VDH teams identified and used in local drills as resources to local hospitals

Training should occur in conjunction with area, state and federal law enforcement agencies

7. Methods of Training

Combinations of training were suggested: classroom training was seen as helpful in two regions(and was not seen as helpful in the other region), and computer/web-based systems (web-sites, web casts, CD Roms) were also identified. Computer training was seen as desirable in two of three regions as supplements to classroom training or in place of classroom training in the case of one region. Interactive training using exercises and hand-on approaches are seen as desirable. Need "just-in-time training" that physicians can get to as needed. The demands on physicians' time to complete training was seen by one region as very great, and therefore will have to be addressed in mounting any training activities. One group felt that CD-Roms would not be used unless made a condition of licensure.

The importance of CMEs was reported across all three groups. Physicians feel that offering CMEs would be very important to offering and completing training. These CMEs should be offered through teaching hospitals in the state, American Academy of Family Practice, or ACEP, and training must be relevant to needs of physicians.

Resources and web sites found helpful were reported by participants as: Audio Digest through the California Medial Society, CDC , USARAID web site, American Academy of Pediatrics, emedicine.com, and Board of Medicine web-site. Gideon website is useful for identifying infectious diseases. Also mentioned were MD Consult and Hippocrates.

8. Medical Reserve Corps (MRC)

In general, there was widespread lack of knowledge among ER physicians concerning this effort. When questioned about MRC, only a handful of physicians reporting hearing about the concept.

9. Suggestions for State in Developing/Implementing MRC

Clarify expectations of the state for use of volunteers, and how MRC relates to other volunteer efforts and DMAT

Surge capacity issues need to be addressed through MRC, and financial resources need to be made available to get the concept implemented and funded properly

Focus clearly on competencies and credentials for participation (volunteers need latest-up-to-date skills and knowledge)

Check background of volunteers

Consider licensing issues

Consider appropriate timeframe for volunteering

First 72 hours is when volunteers will be needed, until the time when full state and federal resources will be available (after first 72 hours)

VDH should establish a centralized data bank of approved volunteers so that volunteers can be quickly accessed in times of need, and so that hospital ERs can know in advance the additional resources they can count on

VDH needs to have special ID badges for all volunteers to enable participation and to allow access to facilities and emergency set-up areas

Recognize that volunteers have concerns about the safety and security of their own families, and that this may limit volunteers' availability in times of need; it was noted that nurses and other health care professionals who are single Moms will NOT respond to a BT event and this reality must be appreciated by VDH

V. Recommendations

Based on the Focus Group findings for Infectious Disease Coordinators and the results of the Safety/Security Officer Survey, we offer the following recommendations to the Virginia Department of Health:

1. Develop and implement a process for improved communications within VDH and between VDH and hospitals within the state, regarding emergency preparedness and emergency response, and assume greater leadership in this area.
2. Establish and implement a formal plan of training for hospitals that focuses on both strategic (delineation of roles and command) and operational aspects of emergency preparedness and response (knowledge and skills in responding to specific types of emergency events). Of particular importance is training in the areas of decontamination, sterilization, and quarantine, and effectively responding to chemical and radiological events. Plan should also address:
    a. use of different methods of training (classroom, on-site and computer/web based) accompanied by an assessment of competencies
    b. use of experts in various content areas as trainers
    c. inventory of training programs in the state that could be used by providers
    d. consideration of issuance of CEUs and CMEs, although the findings suggest that CEUs are not a motivating force for ICPs and safety/security officers in desiring training, Emergency Nurses viewed CEUs with mixed importance, and Physicians saw CMEs as very important.
    e. evaluation of training efforts, and modifications of training based on changing needs of providers
3. Incorporate suggestions for development and implementation of the Medical Reserve Corps Program, and increase communication and publicity for the program in order to boost the number of volunteers.
4. Review findings presented in the report as training programs are designed and implemented.

Appendix A
Hospital Safety/Security Professionals Emergency Preparedness Training Needs Assessment Questionnaire, Cover Letter and Premium Forms

November 19, 2003

Dear Hospital Safety/Security Professional:

RE: Emergency Preparedness Training Needs Assessment and $25 premium for completing this survey.

Please return the questionnaire and request for premium by December 7, 2003

You are being asked to participate in a Virginia Department of Health research study conducted by Christopher Nye, Dr. Jon Thompson and Dr. Richard Travis from James Madison University. The purpose of this study is to determine the emergency preparedness training needs of hospital Safety/Security personnel in Virginia hospitals for biological, chemical, radiological, nuclear, and explosive events.

Individuals returning this questionnaire and request for premium will receive a $25 check for participating in this study. The procedures for receiving the premium are at the end of this letter.

Potential Risks & Benefits

The investigator does not perceive any risks from your involvement in this study.

Research Procedures

This study consists of a questionnaire that will be administered to individual participants in safety/security positions in Virginia hospitals. You will be asked to provide answers to a series of questions related to the training that you think is necessary for emergency preparedness for biological, chemical, radiological, nuclear, and explosive events.

Confidentiality

The results of this research will be submitted to Dr. Travis and Dr. Thompson. While individual responses are kept in confidence, aggregate data will be presented representing averages or generalizations about the responses as a whole. Your individual responses are anonymous and will be held in confidence. No individual responses will be presented in the final form of this study. All data will be stored in a secure location only accessible to the researchers. At the end of the study, all records will be shredded.

You will note that there are no personal identifiers on the questionnaire and that there are separate envelopes for (1) returning the questionnaire and (2) the request for premium.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions

You may have questions or concerns during the time of your participation in this study, or after its completion. If you have any questions about the study, contact travishr@jmu.edu, phone 540 568-3953

Giving of Consent

I have read this cover letter and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. I certify that I am at least 18 years of age.

H. Richard Travis
Name of Researcher (Printed)

Name of Researcher (Signed)

November 19, 2003
Date

For questions about your rights as a research subject, you may contact the chair of JMU's Institutional Review Board (IRB). Dr. Janet Gloeckner, (540) 568-7084, gloeckjw@jmu.edu.

Directions for Returning the Questionnaire and Premium Request

A. Returning the questionnaire (separate envelope)

***Return the completed questionnaire** by December 7, 2003 **in self-addressed, stamped envelope stating** Completed Questionnaire.*

B. Request for $ 25 premium (separate envelope)
(Continued on next page)

B. Request for $ 25 premium (separate envelope)

The information sent for the $ 25 reimbursement/premium will be held in strict confidence and not shared outside the James Madison University Payroll Office

1. ***Fill and sign the Hospital Safety/Security Emergency Preparedness Training Needs Assessment Questionnaire Invoice. We need:***
    a. ***Name***
    b. ***Address***
    c. ***Social Security Number***
    d. ***Signature***
    e. ***Date***

2. ***James Madison University Request for Taxpayer Identification Number(s) and Certification Substitute Form W-9. We need filled out:***

    a. ***Legal Name***
    b. ***Mailing Address***
    c. ***Check the individual box and enter your Social Security Number***
    d. ***Signature***
    e. ***Date***

3. ***Put both (1) the invoice and (2) James Madison University Request for Taxpayer Identification Number(s) and Certification Substitute Form W-9 in the enveloped marked*** *Premium Request.*

We need both 1 and 2 to process your check. Please send by December 7, 2003.

Thank you for your help with this important project.

James Madison University for
Virginia Department of Health

Hospital Safety/Security Professionals Emergency Preparedness Training Needs Assessment Questionnaire

PLEASE RETURN BY DECEMBER 7, 2003

Organizational Data

State Hospital Emergency Planning Region (See enclosed list and put an X beside the appropriate Region)
___North ___Cent. ___East ___NW ___SW1 ___SW2

Number of Licensed beds_____

Number of FTEs (Full time Equivalent employees):
Hospital_____ Security Department _____

Ownership: Not-for-profit_____ For-profit_____ Government_____ Other_____

Perception of Emergency Preparedness and Response

Please indicate your level of agreement with the following statements regarding your Department's emergency preparedness for a:
Biological Event
Chemical Event
Radiological Event
Nuclear Event
Explosive Event

SA = Strongly Agree A = Agree N = Neutral D = Disagree SD = Strongly Disagree

1. Our Security Department has adequate training to handle large crowds coming to our facility for these events. SA. A. N. D. SD.

2. Our Department is adequately prepared for decontamination procedures for:
biological events SA. A. N. D. SD.
chemical events SA. A. N. D. SD.
nuclear/ radiological events SA. A. N. D. SD.
explosive events SA. A. N. D. SD.

.

3. Our Department has adequate personal protection training to protect us personally from:

biological events	SA.	A.	N.	D.	SD.
chemical events	SA.	A.	N.	D.	SD.
nuclear/ radiological events	SA.	A.	N.	D.	SD.
explosive events	SA.	A.	N.	D.	SD.

4. Our Department has readily available information on hazardous materials and how to use these resources for:

biological events	SA.	A.	N.	D.	SD.
chemical events	SA.	A.	N.	D.	SD.
nuclear/ radiological events	SA.	A.	N.	D.	SD.
explosive events	SA.	A.	N.	D.	SD.

5. Safety/security and fire/rescue personnel are completely aware of their specific responsibilities (division of labor) in

biological events	SA.	A.	N.	D.	SD.
chemical events	SA.	A.	N.	D.	SD.
nuclear/ radiological events	SA.	A.	N.	D.	SD.
explosive events	SA.	A.	N.	D.	SD

6. Our Department has been trained on how to preserve the scene for evidence for

biological events	SA.	A.	N.	D.	SD.
chemical events	SA.	A.	N.	D.	SD.
nuclear/ radiological events	SA.	A.	N.	D.	SD.
explosive events	SA.	A.	N.	D.	SD

7. Our Department has been trained in the concept of incident command for:

biological events	SA.	A.	N.	D.	SD.
chemical events	SA.	A.	N.	D.	SD.
nuclear/ radiological events	SA.	A.	N.	D.	SD.
explosive events	SA.	A.	N.	D.	SD

8. Our Department is aware of specific techniques to make our facility less vulnerable to:

biological events	SA.	A.	N.	D.	SD.
chemical events	SA.	A.	N.	D.	SD.
nuclear/ radiological events	SA.	A.	N.	D.	SD.
explosive events	SA.	A.	N.	D.	SD

9. Our Department has performed a risk assessment for:

biological events	SA.	A.	N.	D.	SD.
chemical events	SA.	A.	N.	D.	SD.
nuclear/ radiological events	SA.	A.	N.	D.	SD.
explosive events	SA.	A.	N.	D.	SD

10. Our Department has participated in statewide emergency preparedness drills SA. A. N. D. SD

Perception of Training Experiences and Needs

11. Our strongest need for training is in the area(s) of **(more than one can be selected)**
    a. specific information e.g., knowledge of specific agents and control techniques
    b. planning for specific events
    c. incident command both individual facility and joint with local fire/police
    d. drill coordination for each of the five categories
    e. decon equipment
    f. other _____

12. What method of training do you most prefer?
    a. classroom setting including hands-on training
    b. CD roms sent to me for self-paced training
    c. Web-based methods
    d. other _____

13. If classroom training is used, what is your preferred location?
    a. in my locality
    b. travel to another location outside my immediate area.
    c. at our facility

14. What is your Department's preferred length of time for traditional classroom training?
    a. one hour
    b. 3 hours
    c. 4 hours
    d. 8 hours
    e. 1-2 days

15. How many times a year would your facility be able to allow attendance at classroom training?
    a. one time
    b. two times
    c. three times
    d. four times
    e. more that four times

16. Is receiving continuing education units (CEUs) important in this training?
    a. yes
    b. no

17. Please list the specific emergency preparedness training that you would like the Virginia Department of Health to develop.

18. In the past 12 months, what training has your Department received and who provided it?

Training?	Who Provided?	Total Hrs.?

19. Please rate the effectiveness of any training services/activities that you have attended provided by the Virginia Department of Health on a scale of 1-5 where 1 is excellent and 5 is poor.

Course	Rating : (Excellent) 1 2 3 4 5 (Poor)

20. What print or web sources have you found were helpful for information on biological, chemical, nuclear, radiological, and explosive events?

21. What 3 actions should the Virginia Department of Health take in order to improve emergency preparedness within the Commonwealth?

1._____

2._____

3._____

General Questions: We would also appreciate your input to the following general questions:

22. Do we need to have standard emergency codes (e.g. all numbers and colors mean the same thing) for all hospitals in Virginia?

___Yes

___No

23. The Virginia Department of Health should take a leadership role in developing and providing training on emergency preparedness for hospitals and health care providers. SA. A. N. D. SD

24. If CEUs are important in emergency preparedness training, what organization should be approached to sponsor the CEUs

25. Would you be willing to participate in a **local** volunteer Medical Reserve Corps?

26. What suggestions do you have for Virginia in its efforts to develop and implement the Medical Reserve Corps in Virginia?

Thank you for completing this questionnaire and **returning it by DECEMBER 7, 2003**

Please return the completed questionnaire in the envelope marked "Completed Questionnaire"

Use the separate envelope (Premium Request) to return your request for the $ 25 premium and JMU Request for Taxpayer Identification

James Madison University
Emergency Preparedness Training Needs Assessment
Hospital Safety/Security Professionals Questionnaire

Invoice

Account # 530346

I have completed the Hospital Safety/Security Professionals Emergency Preparedness Training Needs Assessment Questionnaire and thus qualify for the $ 25 premium.

PLEASE PRINT CLEARLY OR TYPE

Name_____

Address _____

_____

Social Security Number _____

Signature _____ Date_____

JAMES MADISON UNIVERSITY
REQUEST FOR TAXPAYER IDENTIFICATION NUMBER(S) AND CERTIFICATION
Substitute Form W-9

……..……..……..……..……..……..……..……..……..……..……..……..……..……..……..……..……..……..…
…..……..………

Each person or organization doing business with the Commonwealth of Virginia must provide the following information:

Legal Name

____
(must match the Social Security Number, if applicable)

Trade Name

____
(must match the Employer Identification Number, if applicable)

Mailing Address

____

________________________ _________ _____________ ___________________
City State Zip Country

Contact Person ________________________________ Business Phone (_______) _______ - __________

Dun and Bradstreet Number
____

ORGANIZATION ENTITY AND TAX IDENTIFICATION NUMBER (TIN) – The number provided in this section will be used to report payments to the IRS, if applicable.

Organization Entity: Taxpayer Identification Number (TIN) (must complete):
Check Only One: Social Security No: Employer Identification No:

|__| I – Individual |__|__|__|__|__|__|__|__|__|

|__| A – Foreign Individual * |__|__|__|__|__|__|__|__|__|
(See Below)

|__| E – Sole Proprietor |__|__|__|__|__|__|__|__|__| AND |__|__|__|__|__|__|__|__|__|

|__| B – Partnership |__|__|__|__|__|__|__|__|__|

|__| C - Corporation

|__|__|__|__|__|__|__|__|__|

|__| S – Sub Chapter S Corporation

|__|__|__|__|__|__|__|__|__|

|__| M – Medical Corporation

|__|__|__|__|__|__|__|__|__|

|__| G – Federal or State of Virginia/ Governmental Entity

|__|__|__|__|__|__|__|__|__|

|__| L – Local or Other State Governmental Entity

|__|__|__|__|__|__|__|__|__|

|__| T – Trust or Estate

|__|__|__|__|__|__|__|__|__|

|__| N – Nonprofit Organization ** (See Below)

|__|__|__|__|__|__|__|__|__|

|__| J – James Madison University Employee

|__|__|__|__|__|__|__|__|__|

***THE UNIVERSITY WILL WITHHOLD 30% TAXES FOR PAYMENT TO FOREIGN INDIVIDUALS UNLESS NOTIFIED OF ALLOWABLE EXEMPTIONS.**

******ONLY IF organization (association, club, religious, charitable, education or other group) is tax exempt under IRS Code Section 501(a). Note : This includes organizations exempt under IRS Code Section 501(c)(3).

CERTIFICATION: Under Penalties of Perjury, I Certify That:

(1)The number(s) shown on this form is (are) the correct taxpayer number(s) (or I am waiting for a number to be issued to me), and (2) I am not subject to backup withholding either because I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding. (You must CROSS OUT ITEM (2) above if you have been notified by IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return).

Signature _____

Date:_____

Print Name of Authorized

Signor_____

Appendix B

Focus Group Questions

1. What is your view of the role of public health in preparedness and response for chemical, biological and nuclear emergencies?
2. Are you aware of the means to contact/access the public health system in times of need?
3. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was your perception of how well the system worked?
4. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Readiness activities?
5. How much involvement have you had in Emergency Preparedness and Readiness planning?
6. The following questions relate to opportunities for assisting local providers:
    - -what areas of EPR training are you most in need of (substantive vs. planning and coordination)?
    - -what methods for receiving training do you most prefer?
    - -if traditional classroom training is desirable, what are preferred locations (off vs. on-site) and what is preferred length of time for a training session?
    - -how frequently during a given year would you be willing to attend traditional classroom training?
    - -are alternatives to formal classroom training (e.g., CD roms, self-directed tutorials, web-based methods, etc.) of interest to you?
    - -are continuing education credits (CEUs) important to you in receiving training?
    - -what organizations should be used to sponsor CEUs?
    - -what print or web resources put out by other organizations have you found to be helpful? How should the Department of Health make these available to professionals like you?
7. Would you be willing to participate in a local volunteer Medical Reserve Corps?
8. What suggestions do you have for the state in its efforts to develop and implement the Medical Reserve Corps in Virginia?

Appendix C
Focus Group Consent Form

Consent to Participate in Research
Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by H. Richard Travis and Jon Thompson from James Madison University. The purpose of this study is to ascertain the emergency preparedness training needs of (1) safety officers in general, community, and acute care hospitals, (2) hospital infectious disease coordinators, and (3) emergency room physicians and nurses.

Potential Risks & Benefits

No risks are anticipated. The benefits will be a better understanding of emergency preparedness training needs in Virginia.

Research Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction.

This study consists of summarized recommendations for the content and methods of delivery regarding emergency preparedness needs in Virginia.

Confidentiality

All of the information provided by informants for this research will remain confidential. The focus groups will be recorded and comments transcribed. In addition, facilitator notes and summaries on flip charts will record comments. Participants will be asked to not identify themselves when making comments. The tapes, transcriptions notes, and flip charts will be destroyed at the end of the research project.

The results of this research will be a final report with an executive summary that will be sent to Suzi Silverstein, Director of Education and Training Emergency Preparedness and Response Programs Virginia Department of Health. The executive summary will be placed on the Virginia Department of Health website, http://www.vdh.state.va.us/ and participants will be directed to it to obtain a summary of results. The participants way also contact us to receive the executive summary. While individual responses are kept in confidence, aggregate data will be presented representing averages or generalizations about the responses as a whole. All data will be stored in a secure location only accessible to the researcher. Upon completion of the study, all information that matches up individual respondents with their answers will be destroyed.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions

You may have questions or concerns during the time of your participation in this study, or after its completion. If you have any questions about the study please contact:

H. Richard Travis, Ph. D., Department of Health Sciences, MSC 4301, James Madison University, Harrisonburg, VA 22807 Phone 540 568-3953, EMAIL travishr@jmu.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

Name of Subject (Printed)	Name of Researcher (Printed)
Name of Subject (Signed)	Name of Researcher (Signed)
Date	Date

For questions about your rights as a research subject, you may contact the chair of JMU's Institutional Review Board (IRB). Dr. Janet Gloeckner, (540) 568-7084, gloeckjw@jmu.edu

Appendix D

Infectious Disease Coordinators Focus Group Abingdon, VA October 17, 2003 Summary

1. What is your view of the role of public health in preparedness and response for chemical, biological, and nuclear emergencies?

   Education and information on what to do if there is an event.

   A checklist of what to do, and this would be in emergency room. This checklist is not available at this time.

   If a chemical event occurred, EMS personnel seem to know what to do at this time in our area, but not the nursing staff at the hospital.

   To have personnel who can quickly come on site if an event happened.

   To provide contacts if there is an event.

   To have a coordination/communication role of public health departments and hospitals.

   There is the expectation that the VDH will have the answers if an event occurs and will be readily available to help.

   Need to train the general public before telling them a head of time of what to do.

2. Are you aware of the means to contact/access the public health system in times of need?
   There are numbers to contact on a 24 hours basis although the system has not been tested yet.

   The hospitals in the area have a list of who to call, and 800 numbers for other localities.

3. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was your perception of how well the system worked?
   There were two incidences and the system worked well in this area.

4. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Readiness activities?

   Not very concerned about this. They feel that the current system through the health departments is working well, and that this would extent to emergency preparedness.

They express confidence that they could get help if needed.

5. How much involvement have you had in Emergency Preparedness and Readiness planning?

There is a task force for Southwest Virginia that had has good involvement of health departments, individual hospitals, and the community.

They feel that they have been involved in emergency preparedness training.

6. The following questions relate to opportunities for assisting local providers:
   What areas of EPR training are you most in need of?
      Recognition of the substance and what do I do with the person immediately, what do we do with the contacts these people have had such as family members and fellow workers, decontamination procedures, many of these infectious disease coordinators are the only infectious disease control persons in their hospital so they need to have backups training or readily accessible contacts 24 hours a day or someone that they can contact to confer/consult about their decisions, list of agents and their symptoms.
   Planning training:
      No needs for planning training
   Coordination training:
      Need a standard process for protocols of what to do that are the same across the entire state for all staff members – doctors, nurses, infectious disease coordinators, and emergency room staff.

   Methods of training:
      Most prefer traditional interactive, hands on classroom training. The interchange between participants is important.

      The time frame for training was one to two days with the thought that as coordinators that this would a train the trainers format where they would come back and then train other hospital personnel. With this train the trainers format, it would be good to have other members of the hospital trained at the same time to form a team of trainers rather than just one person.

      On-line and CD sources could be used for some topics that would be less than one hour. People would not go to a website over a long period of time to take a course.

      In would be useful to have someone to respond to questions in real time.

      They would like an initial training and then as changes come up. If the training has cost, there is a budget time lag for planning.

CEUs are not important currently for infectious disease coordinators, as they have to retake an exam every five years.

Useful print or web sources:
CDC.gov
UNC Chapel Hill spice
APIC

7. Would you be willing to participate in a local volunteer Medical Reserve Corps?
   Most replied yes but felt that they were adequately trained. But they will busy with responsibilities at their own hospital.

8. What suggestions do you have for the state in its efforts to develop and implement the Medical Reserve Corps in Virginia?

   The State needs to clarify expectations.

   Are willing to help locally but travel would be difficult due to professional and family responsibilities.

   What time commitment.

   Will there be multiple teams and a definite tour of duty.

   Are there any liability issues?

Appendix E

Infectious Disease Coordinators Focus Group Richmond, VA October 17, 2003 Summary

1. What is your view of the role of public health in preparedness and response to chemical, biological and radiological emergencies?

Leadership—reporting of activities and assisting with appropriate ways to respond to these events; providing effective and timely communications; help ICPs manage their facilities

Educating the public—accurate timely information for example regarding shelters, clinics

Distribution of resources to hospitals such as meds and supplies

Assess and communicate needs—status of facilities (including hospitals, clinics , LTC centers). Example—Patient First not open during recent Hurricane, dialysis machines not operational due to power failures)

Understand role of ICP and hospital—VDH needs to understand the demands on hospitals and place personnel in hospitals where they can; it was noted that greater support and communication is occurring now compared to before

2. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Readiness activities?

Communications need to be strengthened within VDH and between VDH and facilities—it was noted that there is a lot of variability in nature of information communicated depending on who you talk with in VDH.

Education of hospital staff—VDH has done some programs for hospitals ICPs by coming to meetings of ICPs and presenting key info, but this should be expanded

Variation in information disseminated because all facilities do not get fax blasts, and some rely on state while others rely on districts for info

Communication still a big issue

Hospitals don't know who to contact at VDH for specific problems

VDH doesn't have contact numbers of appropriate parties at hospitals to contact for specific issues in an emergency—VDH needs to define the relevant issue(s), and then contact appropriate party at each hospital

Quickly identify potential outbreaks; provide assistance when requested on certain events (e.g., potential of SARS).

Educate private physicians.

Develop summary fact sheets on various emergency preparedness issues.

BT education for public so that everyone is speaking the same language.

3. Are you aware of the means to contact/access the public health system in times of need?

Yes, all know how, due to weekend access numbers, telephone number of VDH epidemiologist; also have telephone numbers and beeper numbers to access VDH in event of emergency

4. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was your perception of how well the system worked?….

Problems in follow-up of outbreak, and potential SARS case

5. How much involvement have you had in Emergency Preparedness and Readiness planning?

Alot…comes through hospitals primarily and APIC (Association for Practitioners of Infection Control). MCV did a course on BT for hospitals staff that many participants attended.

Don't rely on VDH for this training

VDH can help with ensuring that training in state is comparable and all on same page.

It as noted that there is much variation in training across the state sure to the vast rural areas of state.

6. The following questions relate to opportunities for assisting local providers:

Substantive training areas were identified as follows: SARS, nasal flu vaccines, radiological /chemical training. Updates on new diseases and how to cope with existing concerns (BT) are areas that VDH should focus on. It was noted that VDH seems to wait on providing recommendations from CDC rather than providing recommendations in a timely fashion. Hospitals are looking for guidance from VDH on these matters.

Methods of training: web casts; Blast Fax for all hospitals and informing ICPs as to what action is needed specifically; educating medical staff directly at their own offices; Field Epi Seminars; classroom training

Web site: make Powerpoint slides available from various presentations on the VDH web site; share other info on VDH web site; CD Roms and web-tutorials not seen as helpful to this group due to time constraints

7. Would you participate in a local volunteer Medical Reserve Corps?

Two in group had heard of it, and those who had heard knew its purpose. Several were not sure what VDH's role in MRC is.

8. What suggestions do you have for the state in its efforts to develop and implement the Medical Reserve Corps in Virginia?

Publicize it

Focus clearly on competencies and credentials for participants (want volunteers to have the latest, up-to-date skills and knowledge)

Coordinate with HEICS (Hospitals Emergency Incident Command System)- each hospital in the Richmond area is participating in this system and MRC efforts must be coordinated with the incident command program at each hospital

Appendix F

Infectious Disease Coordinators Focus Group Virginia Beach, VA October 24, 2003 Summary

1. What is your view of the role of public health in preparedness and response to chemical, biological and radiological emergencies?

Leadership on coordination in planning and response to events; recent "Table –top" exercise shows the need for VDH to take active command role

Information dissemination to the public – VDH should take strong role in coordinating communications to public in an event

Information coordination for al relevant organizations and entities for BT and infectious diseases; VDH needs to coordinate within VDH for effective communications prior to communications externally

Develop a plan and implement the plan for Emergency Preparedness--participants said that they have not seen plan which point out roles of VDH and individual providers in the event of an emergency. If it is available, then it is not well publicized to providers. One participant stated that advisories had been forthcoming from VDH on SARs and smallpox in the past and that they have been helpful

Coordinate state lab services-this is a resource for all hospitals in state; hospitals labs could become contaminated and therefore have to close—what is the role/plan for state lab as a back-up?

Plan for and train providers- develop centralized resources to bring to site of an event

Show interest and advocacy for the state—since 9/11 interest among public and providers has waned—it is VDH's role to keep the interest and momentum

2. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Response?

Deficiencies in communication: inefficient (one staff has to talk with another who talks with another, etc., to get a decision), There is no back-up on weekends and evening since it has not been viewed in the past as a 24/7 function; lack of staff as they are pulled in different functions; high variation in local decisions/actions/support for providers

VDH resources limits (budget cutback, low salaries, and historical high turnover)

Development of a plan-group is unaware if there is a plan and if it can be implemented in the event of an emergency; examples of delay in getting an "Alert" out

HIPAA reporting and getting information from providers—can't just release info now as they used to and this requires duplication of reporting

Understanding role of providers and that hospital providers cannot just drop everything to get VDH data on certain patients to explore cases/provide data, and that hospitals don't have all the data at their disposal that VDH thinks they do; hospital administration doesn't understand expectations of public health on their organizations. One participant stated that VDH staff and hospital staff work well together.

Lack of a plan for training: Table top drills are ok, but there is no training plan that has come out of drills; no training plan exists; role and expectations of VDH in providing assistance in the event of an emergency are not specified (the assets of the VDH have not been identified in terms of what hospitals can rely on from VDH)

Need to increase marketing of training efforts to emergency providers and PCPs-these are front-line providers who need training

Be a role model for state—VDH is behind in public health efforts compared to other states (VDH behind in getting their own staff vaccinated against small pox, let alone other healthcare workers in the state); hospital administration respond to state agencies and VDH must keep the preparedness issue salient for the state; VDH must have a prospective view now as opposed to traditional view of retrospective analysis of cases

3. Are you aware of the means to contact/access the public health system in times of need?

Yes, local numbers to access the local HD are known, either for Hot-line access or 24 hours on call. Many reported that they had personal relationships with HD that facilitated contact, rather than system contacts.

4. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was your perception of how well the system worked?

Yes, but the experience has been less than favorable. Examples were given by participants that indicated delays in accessing the responsible party, and numerous individuals that had to be called to get the right person. In one case, a participant reported calling another jurisdiction to get through to the party needed to talk to in the *local* jurisdiction. In another instance, VDH responded to a request for assistance, however, there was no additional information that could be provided by VDH.

5. How much involvement have you had in Emergency Preparedness and Readiness planning?

Yes, significant…most done at hospital level and through professional groups. Most has focused on biological training. There is a need for chemical and radiological preparedness training. Also, there is a need for knowledge of the resources that exist within the state to aid in responding to emergency events and what providers can rely on from the state.

There is also a need for public information actions of VDH: Community forums to address public concerns (e.g., deaths from flu-like symptoms), interaction with schools; booklets to address BT and other events; it was pointed out that VDH is in the perfect objective position to address these issues rather than hospitals who may be viewed as having biases and self-interests.

6. The following questions relate to opportunities for assisting local providers:

Substantive training areas were identified as follows:

There is a great need to clarify expectations for both providers and public health department in terms of actions to be taken in responding to emergency events Chemical and radiological training are needed for all types of providers. PPE training for specific events was noted, as well as the opportunity for VDH to do "fit-testing" of the PPE.

Training needs may be different for medical, nursing and ED staff, and there should be targeted training based on those needs

Methods of training:

Combination of training methods are desired: classroom training with recognized experts would be helpful (not just VDH staff, but well known experts in the field is best). VDH could sponsor the training but use experts; one participant stated it was unclear if VDH has the expertise to offer the training. Remote access training such as web based and CD Rom would be helpful and would be used.

It was emphasized that "just in time" training appropriate to events that occur would be helpful so as to not wait for information. Targets for training (medical, nursing and others) should be identified and appropriate training developed to meet their unique needs.

Training needs to be tied to overall plan for Emergency Preparedness.

Training programs must be evaluated and training changed to reflect changing needs of providers and success of training efforts. Don't just give attendees handouts.

If CEUs are determined to be needed, then would have to work with professional associations as there is no requirement for nurses in Virginia to complete CEUs.

7. Would you be willing to participate in a local volunteer Medical Reserve Corps?

A couple participants had heard about this program and knew in general what it is. (See comments below under #8).

8. What suggestions do you have for the state in its efforts to develop and implement the Medical Reserve Corps in Virginia?

Concerns:

1) Focus on desired skill levels that are needed

2) Will it fit-in with the existing response system in the state?

3) Liability issues of volunteers

Suggested to set it up along the lines of a military reserve program model where jobs and seniority would be preserved if health care workers were going to be pulled from various parts of the state for prolonged period of time. It was suggested that this may need to be tied to Virginia Homeland Security and laws established to make this a more formal organizations with authority to activate in terms of a serious event.

Has to be tied to training plan (like military reserves) that bring skill levels up to desired levels for completion of responsibilities

"Fear factor": there is a lot of difficulty in getting people to become first responders in these cases where you have to deal with issues like this that are unique in care delivery. Therefore, can you find a pool of people to do this? Not sure. Recognize that a lot of health care personnel are fearful of exposing themselves/their families to various events, and that may hamper efforts to build up a solid reserve.

Most would agree that before they would do this, they have to get answers to these questions.

Other issues raised:

Consider alternate care sites. Hospitals cannot address this as it is outside their walls of operation. It is up to VDH to address this in terms of "surge capacity."

Appendix G

Infectious Disease Coordinators Focus Group Roanoke, VA October 29, 2003 Summary

1. What is your view of the role of public health in preparedness and response for chemical, biological, and nuclear emergencies?

   The leader and guidepost for us to go to and coordinator of interagency communication.

   Providing consistency for the public and medical community with educational material on how to identify the agents and treatment methods.

   Provide coordination with hospitals, private physicians, schools, and then general public.

   In developing training programs, realize that coordinators have other responsibilities also and not overwhelm them with detail, be practical with information and training.

   Keeping information and treatment methods up to date.

   Work with the media to develop a quick media response if there is ever an event. The material would be ready for dissemination. Let the general public know, with a consistent voice, what they are to do.

   Have one voice talk when there is an event rather than a multitude of sources.

   Anticipate equipment needs and fast distribution of these, e.g. if several localities needed a specific type of ventilator, are these available and can they be quickly moved?

2. Are you aware of the means to contact/access the public health system in times of need?
   There was a resounding yes to this question. They have telephone numbers, cell phone numbers, pager numbers and others.

3. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was your perception of how well the system worked?

   One participant shared that it took 20-30 minutes to talk to an individual. There was an initial short recording at first, but it did not provide the necessary detail.

   Another participant got a response quickly, and local numbers are working well and meet their needs.

There is the expectation that the infection control practitioner contacts the local health department and the local health department contacts the State.

4. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Readiness activities?

   There does not appear to be effective communication between State and localities and this was apparent in a recent "Table Top" exercise. In this exercise, there was good communication between local hospitals but not from the State to the localities. The State may have thought (the perceived perception of the State) that the communication from them to local level went well, but it did not.

   Information may sometimes come to a local coordinator but does not get sent to other practitioners.

   Presently, they feel that they are not getting current and appropriate information from the State.

   There was a recent drive and no one received a HAN Alert, a sheet sent out by fax. They expected to receive these. Several participants shared that they had received an email in the summer asking if they were receiving HAN Alerts. Even though they had responded to the emails, no HAN Alerts were received in the recent drill. Therefore the HAN system needs to be tested. Where are the messages being sent? If they are sent to a local health department, no one is on duty on weekends for fax or commuter messages.

   In this recent drive, the State requested hospitals to be involved but the local bioterrorism planer and staff were not contacted at all. State Department health officials contacted infection control practitioners, and some even got written plans, but the local level people were not involved in communicating with the State.

   In other facilities, infection control practitioners were not contacted at all but heard information about the drill from the Emergency Department.

   Overall, there are concerns about the level of communication from the State; State and local people who have responsibilities for bioterriorism response were not talking to each other in this recent drill.

5. How much involvement have you had in Emergency Preparedness and Readiness planning?

   There has been involvement in planning at the local level.
   One participant had involvement at the regional level

6. The following questions relate to opportunities for assisting local providers:

What areas of EPR training are you most in need of?

Content/information needs:

Hard copy of chart with agent, symptoms, treatment, protective equipment. Standardization of type of protective equipment in relationship to specific agent incident, everyone has the same chart/grid, radiological events, are there still shelter with a radiological event, how assist the public and large number who present themselves at our facility, need ready access to the material when we need – readily accessible, more information on chemicals and treatment measures,

Planning training:

No suggestions offered

Coordination training:

sharing of physical and people resources in the case of an event - people will be using same equipment and chart/grid, how to run an incident command center and division of responsibilities.

Methods of training:

Most prefer traditional interactive, hands on classroom training. The interchange between participants is important.

When a "Table Top" exercise is developed, there should be resolution of the exercise with a handout so that the people leave with something such as a summary of what they did and recommendations how these procedures could be used in the future. This should be more that just an exercise. Otherwise, unless you make detailed personal notes, you get nothing when you leave the exercise other than satisfaction of doing the process.

Mixed suggestions on whether on site or local training. Offsite has the advantage of meeting and sharing with other people. The length of training ranged from about 8 hours for one or two days training. If it were a shorter course, four hours is a good time frame. Quarterly training programs would be acceptable

CD ROMs, audiotapes and web site training programs would not be used. Perhaps, have training first and then bring on for a resource.

CEUs are not important currently for infectious disease coordinators. However, other staff working with the infectious disease coordinators may need these. If Virginia changed licensure requirements, CEUs may become important. Some professional organizations may require CEUs

Possible CEUs providers would American Nurses Association,

Useful print or web sources:

CDC.gov

USAMRID
UNC Chapel Hill spice

7. Would you be willing to participate in a local volunteer Medical Reserve Corps?
Most replied yes but felt that they will be needed in their facility

8. What suggestions do you have for the state in its efforts to develop and implement the Medical Reserve Corps in Virginia?

What will be my responsibilities?
Recruit retired healthcare professionals and make sure that their training is up to date.
Once you have the volunteer list, how do get a hold of them?
Consider using nursing and medical student; they will need to have an instructor present.
What the process in getting the Corps initiated?

What about qualifications, licensure up to date

Appendix H

Infectious Disease Coordinators Focus Group Arlington, VA November 7, 2003 Summary

1. What is your view of the role of public health in preparedness and response for chemical, biological and radiological emergencies?

Provision of information and education to providers (care and treatment of individuals and steps that should be taken in terms of specific responses); education of the provider community was seen as second most important role after communication.

Ensuring availability of supplies and resources (feedback on things you should have in place)

Communication (group thought that this is the most important): constant communication and updates as events unfold at the state-local VDH levels but also within the local health system levels

Information and education to the public: language public can understand, in multiple languages, that can assist in the public "not overwhelming" the hospitals

Work with the media to make sure that it is accurate and have VDH check on reports before being distributed by the media (Hurricane Isabel water example was cited)

2. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Response?

Group expressed lack of knowledge of VDH educational efforts

VDH is assuming a bigger, more important role now: starting to be recognized as an agency that should be listened to, but still fighting old "stigma"

The role of VDH in latest anthrax care (the night before) was not apparent: lag in timely notice to providers, and misinformation; VDH should get this information to ERs prior to the media reports so that providers can know and respond effectively; group raised the question as to how VDH was in the loop on this.

The role of Med Com and public health was discussed: it was noted hat VDH has to agree before a potential problem acted on by Med Com turns into an "alert" from an "advisory"

Variability of faxed information from local districts was identified as a concern (latest Anthrax situation and related information was cited as an example)

3. Are you aware of the means to contact/access the public health system in times of need?

Yes, aware of these methods through telephone access numbers.

4. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was your perception of how well the system worked?

Yes, there were a few instances and the system seemed to work okay.

5. How much involvement have you had in Emergency Preparedness and Readiness planning?

Quite a bit. Most training received from other sources than VDH. Training for one participant in Maryland under a federal grant was cited. Sessions put on by Washington Hospital Center were mentioned.

Some training on anthrax was provided by VDH, but well after the event of 2001.

It was noted that Quarterly Meetings held in Fairfax with VDH, Fire and EMS and ICPs were stopped, and there was uncertainty whether these are being replaced by sessions offered through Washington Hospital Center.

It was noted that hospitals took the lead in the role of anthrax preparedness during 2001 when HDs looked to hospitals for leadership on prescriptions and space to accommodate this

The role of Bio-Medical Actions Teams was discussed, and the positive role of VDH in working with local voluntary physicians in making sure that they can immunize the public (1 million people).

6. The following questions relate to opportunities for assisting local providers:

Substantive training areas were identified as follows

Be more proactive in training (help providers understand the ways bioterrorism can be used)

More collaborative action among various local health departments that cover the region, with providers

More coordination with other organizations (that were mentioned, such as Washington Hospital Center, quarterly meetings locally and State of Maryland) who have provided

training initiatives in the past, and it was felt that VDH should take the lead on these initiatives

Providing updated/timed information: new info is always being developed and disseminated and there is a need to make sure that VDH handles this appropriately and get it out accurately before the media gets it out

VDH should take the lead on education for providers (although is was acknowledged that this should not be the only source, others being local hospitals themselves)

VDH should notify providers on new issues/world issues (since the area is close to Dulles Airport): monkeypox was given as an example and most participants learned about it from *Washington Post* rather than VDH or anyone else

Community-wide focus on education for public

Virology training would be helpful

Information to private docs and primary care centers

(NOTE: there was widespread uncertainty expressed about who actually sponsored the training that participants went to, however, it was felt that VDH has had little role in available training)

Methods of training:

Information dissemination

Some classroom training would be helpful

Web site information

7. Would you be willing to participate in a local volunteer Medical Reserve Corps?

No awareness among participants

8. What suggestions do you have for the state in its efforts to develop and implement the Medical Reserve Corps in Virginia?

It was suggested that physicians have inter-hospital privileges to facilitate aggregate response in an emergency

Other issues raised:

More prepared than they used to be, but not adequately prepared for major events

Perhaps VDH should target hospitals that do not have ICPs to work more closely with them because of a lack of resources

Relationships between hospitals and VDH varies tremendously: while some local relationships are very good due to personal relationships, others are not so good; but hospitals are beginning to recognize the value of VDH efforts and working with them in discussions of hospital preparedness planning and response.

Appendix I

Infectious Disease Coordinators Focus Group Harrisonburg, VA December 5, 2003 Summary

1. What is your view of the role of public health in preparedness and response for chemical, biological and radiological emergencies?

Provide education and information to providers by being a resource to the community (updates on conditions and how to respond) (While most favored this, one participant stated that it could be "their role" but not sure)

Do research and serve as clearinghouse for dissemination of research finings to local communities

Providing resources (manpower, medications, decontamination) in times of emergencies (Example given was smallpox inoculation where staff from local HD came and offered immunizations)

Identifying "best practices"—recommendations on reasonable approaches to response and specifics on how go about doing things (e.g., number of antidotes on hand, best way to decontaminate, etc.; the point was made here that VDH should not be creating demands, but rather offering reasonable, acceptable minimal standards and best practices given that event and resources may be once in a "lifetime"

Many favorable views of VDH and the efforts they have taken recently:

> 24/7 statewide back-up access number (although there were individuals present who did not know about this)
>
> E-mail access and Fax blasts

Favorable customer service, and the point was made that there is a genuine attempt by VDH as to "what can we do to help", and acknowledge that they don't have all the answers

Getting hospital personnel together with others to review "outbreaks" and how they were approached

Coordination of resources--VDH is seeking ways to work within existing structures and the existence of multiple agencies and asking the question "how do we fit into the existing structure/roles" rather than assuming they will take over. But the issue of leadership and "who is in charge" is still a real question facing hospital providers.

2. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Response?

Recent drill was positive and created awareness on the part of hospital administration that this is something hospitals need to be thinking about (although one participant stated that VDH didn't know that facility was participating in drill). Still communications gap in some cases).

Non-hospital organizations have a key role, particularly in creating arrangements for "surge capacity" and must be included in training, education and preparedness issues; VDH must focus on who needs what information and how to get that information to them

Should be a "broader" focus by VDH in involving non-hospital providers (training assistance needed, as well as the management of these facilities need to be educated). However, it was acknowledged that VDH is focusing on training of their own staff and they are still learning as an organization as well.

Adequacy of personnel to handle emergency preparedness and response was raised—it was stated hat VDH is doing lots of things in addition to emergency preparedness and response.

Need for "recipes" for emergency events was raised—over and above policies that organizations have, there is a need for a quick reference guide that reminds individuals what to do and what to consider in responding to events: use of volunteers, securing water in the community, use of schools in terms of shelters, etc.)

3. Are you aware of the means to contact/access the public health system in times of need?

Yes, all participants indicated that they know how to contact the public health department. List of contact people at local levels has been made available. Lists of contacts names, home telephone numbers, beeper numbers and cell telephone numbers have been made available. This has been a recent practice.

4. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was you perception of how well the system worked?

One participant has indicated "yes" and the system worked very favorably (The case was related to a meningitis case).

5. How much involvement have you had in Emergency Preparedness and Readiness planning?

Most participants indicated hat they had received a lot of training (only one indicated that they didn't receive any training). Most training cited was provided by hospitals

organizations or professional associations (such as VHHA, or VHCA). Participants indicated that VDH was not involved in providing training but that VDH was represented in attending these meetings. One participant indicated that VDH had been involved in prior smallpox training.

6. The following questions relate to opportunities for assisting local providers:

Substantive training areas were identified as follows:

How to be supportive of non-hospital providers in training and educational efforts

Understanding the basics of responding to biological, chemical and radiological events: what to do, what NOT to do, etc; how to protect self (use of different types of masks (regular or N-95 masks; sterilization and decon issues (how would you handle if person is contaminated or an area of your facility was contaminated?)

Two levels of training :1) strategic response : More upper level management long term planning for logistical issue; 2) operational response : immediate recognition, containment strategies, decon/sterilization/hazmat issues, etc.

Methods of training:

Need to have creative ways of providing training, with focus on non-traditional types of training

Three methods were suggested: bring participants into state sponsored training (centralized); send experts out to facilities; on-line and web based methods

Training must be evidence-based and knowledgeable: provide state of the art education that participants can say they really learned something when they leave; hearing from someone who has experienced a “threat” is valuable; consistency of knowledge across sessions and across audiences is very important.

Web-based methods need to be interactive and not just reading (test for competencies, etc)

CEUs are not important; the type and quality of training is what will draw people to training

CD Roms may not be attractive to all possible users as people have limited access in some cases to computers and may be unfamiliar with this learning tool

The demands on hospital personnel for training is great, but people cannot judge which training is high quality and their budgets are limited, so it becomes very difficult to assess training options

VDH should be the lead agency in identifying what training courses are available statewide, and identify if "good" training has been prepared by some of the other groups in Virginia (such as regional hospital planning groups) and then make that training available to total state.

7. Would you be willing to participate in a local volunteer Medical Reserve Corps?

Participants had not really heard about it, and therefore were uncertain.

8. What suggestions do you have for the state in its efforts to develop and implement the Medical Reserve Corps in Virginia?

It was suggested that the military analogy be used for this—protect volunteers' jobs when they return, and MRC must assure that they have jobs subsequent to an event

Concerns about the resources that are devoted to this being excessive and taking away from other needs (such as education and training programs for providers)

Volunteers would be concerned about jeopardizing their children and families from being exposed, so this may reduce interest in this program

There is some confusion about registration under nursing licensure that was initiated this year, and whether that meant that nurses would be signed-up for MRC

Other comments:

Relationship with VDH has been very good and communication has increased during recent past. Both VDH and hospitals recognize that relationship is a two-way street and that parties recognize the value of good communication

Appendix J

Summary of Open Ended Questions by Region

An X indicates that this idea has been repeated beyond the initial recording. The first time the idea was recorded; and if repeated again, an "x" was added.

North Region

11. Other
    PPE

12. Other

17. Training that you would like:
    Provide onsite training at no cost to facility
    Response to biochemical situations for first responder, i.e. hospital workers x
    Incident response command communication links and mitigation to WMD xx
    PPE
    Communication at all levels
    Assess priorities
    Training center providing training for decon procedures and recovery
    Crime scene preservation
    Improvised explosive devices (IED) identification

18: What training in past twelve months

Training	Who Provided	Total Hrs.
PPE	Consultant	3
Decon	Consultant	3
Decon	Hospital	10
ASP Baton	Central Trng Academy	8
OC Spray/Handcuffing	Central Trng. Academy	8
Basic PPE	In-house	3-4
Basic Awareness	In-house	
Decon	In-house	6

19. Rate State Training 1= excellent and 5 poor

EMS Management State Form	3
Statewide drill	2

20. Useful print or web courses?

U.S. Army
Dept. Homeland Security
ASIS
State Emergency Management
FBI, TSA, DEA, DOD, DA

21. What 3 actions

Provide fund to hospitals for PPE and training x
Improve overall communications x
Provide on-going training including train the trainer e.g. a training center x x x x (train the trainer mentioned again)
Have the training be joint training with police, fire, and rescue (coordination of training personnel function)
Institute periodic information briefings
Standardize emergency codes
Provide hospitals with a standard PPE package (standardization of response)

24. If CEUs, what organization?
VA Department of Emergency Services

25. Willing to participate in local Medical Reserve Corps?

Yes xxx
Undecided at this time.

26. What suggestions to develop and implement Medical Reserve Corps?

Publicize program
Use existing Fire/EMS people
Recruit college students
Use military reservists
Use private home health agencies

Central Region

11. Other
Response and recovery techniques for WMD incidents
PPE/COBRA

12. Other
    VCR tapes, books and manuals

17. Training that you would like:
    Response and recovery to WMD incidents
    Hands on training on WMD training on personal protective equipment x
    How to deal with large crowds of concerned/contaminated persons
    SARS isolation and setup.

18: What training in past twelve months

Training	Who Provided	Total Hrs.
WMD	USPHS	32
VDH Terrorist Drill Oct. 19-21, 2003	VDH	16
HEICS	In-house	1
Patient decon	Another hospital	8
Crisis Mgmt.	Psychologist	8
HEICS/ICS	In-house	24

19. Rate State Training 1= excellent and 5 poor

VDH Terrorist Drill Oct. 19-21, 2003	2+
Tabletop drill June/03	1

20. Useful print or web courses?
    VA Department of Emergency Management website
    Federal Emergency Management Administration Website
    Homeland Security

21. What 3 actions
    Initiate and involve all entities in the community
    Get police, fire, local government, rescue units and hospitals to drill together
    Initiate and facilitate local emergency response command committees (LERC)
    Coordinate training efforts
    Mandate immediate decon and PPE training for police and security

24. If CEUs, what organization?
    State institutions of higher learning

VA Department of Criminal Justice

25. Willing to participate in local Medical Reserve Corps?
Yes
No

26. What suggestions to develop and implement Medical Reserve Corps?

Keep the MRC as local as possible so they can participant
Coordinate well with the command hospital

East Region

11. Other
security specific training for individuals who may serve in some security capacity

12. Other

17. Training that you would like:
Chemical, biochemical, and radiological incidents xx
Communication procedures
Decontamination equipment usage and procedures x
Develop a listing available related to training by pertinent professional organizations and utilize some of their (organization/professional) train the trainer programs. Then somehow convince VHHA to get hospital admin. To buy into non-clinical staff development.
Coordinate training (MMRS, HRSS)
Security of hospital with WMD

18: What training in past twelve months

Training	Who Provided	Total Hrs.
Bomb threat	In-house	4
none		
Bioterrorist drill	VAB fire dept	6
WMD planning	Hampton sheriff's dept	8
Drills		
Respirator fit training	In-house	
PPE	In-house	
Decontamination tent	In-house	

First Responder	Fire Dept.	16-24
Biological HAZMAT	ED	12
WMD	VDH	4

19. Rate State Training 1= excellent and 5 poor 3

April 2003	Charlottesville	3
None		
Teleconferences		3
HRMMRS		1
WMD		2

20. Useful print or web courses?

CDC,
Twotigers
MMRS
Weekly Homeland Security Newsletter

21. What 3 actions
    - Provide information and coordinate information between regions xx
    - Stay involved with Metropolitan Medical Response System
    - Provide grant money for non-clinical functions related to chemical, biological, explosive, nuclear/radiological events, more effective utilization of existing training programs by other professionals.
    - Develop community training and coordination with media, local EMS, and hospitals and a strike team equipment (debrief hospital prior to going to media) xxx
    - Establish Command Center with hospital reporting function
    - Develop surge capacity guidelines for hospitals
    - Training (bioterriorism, first responder) adapted to rural areas
    - Adapt training to different department responsibilities such as Security and ED.

24. If CEUs, what organization?
    - Nursing and Physician associations
    - State organizations

25. Willing to participate in local Medical Reserve Corps?
    - Yes xx
    - maybe – we are not physicians, many of us have been EMT's but maybe didn't have the time to our last two refresher cycles to go through the classroom requirement.
    - No x

26. What suggestions to develop and implement Medical Reserve Corps?

Take a look at EMT's who let their certification expire, develop training, and recertification program for them.
Use existing EMS personnel as a starting point using county, regional and statewide meetings

Northwest Region

11. Other

12. Other

17. Training that you would like:

Policies/procedures specific to healthcare workers including both clinical and non-clinical areas

Bomb Threats
Bioterriorism preparedness
Handling victims of biological and chemical events
ICS; preparations for bio/chemical events; explosive devices x
Hazmat awareness/operations
CISM
Decon procedures for nursing, housekeeping, and security

18: What training in past twelve months

Training	Who Provided	Total Hrs.
Disaster Manual	Safety Officer	2
Bioterriorism		
Drills & simulations	NW region	4
Drills & simulations	Valley Health System	8
PPE	in-house	1
WMD/Biological	USAF	16
Healthcare safety	in-house	20
Non-violent crisis intervention	CPI	12

19. Rate State Training 1= excellent and 5 poor
none
none

20. Useful print or web courses?

VA Department of Emergency Preparedness
Other hospitals
Homeland security x
FEMA; FBI; Homeland security x
Hazmat for Healthcare
Firehouse.com
CDC

21. What 3 actions

Training curricula and drills xx
Bioterriorism teaching in the facility
Nuclear/radiation preparedness
Produce simple/concise brochure for ED personnel on first response and triage for bio/chem. event victims, assemble list of resource agencies and contact persons and distribute or make available, continue to work at hospitals and other agencies on joint educational activities and drills. x
Coordination of GVPT agencies for hospitals, communications, train the trainer programs
Develop simple templates/guidelines/procedures that all VDH regions will follow
Develop a robust matrix who to call, what first steps in different situations with a clear command structure.

24. If CEUs, what organization?
JMU
UVA
VDH

25. Willing to participate in local Medical Reserve Corps?
Yes xxxx
No
Maybe x

26. What suggestions to develop and implement Medical Reserve Corps?
Do as soon as possible
Would need to consider how to provide emergency credentials; for those in health care their primary job would take priority; would need to recruit outside health care/law enforcement and provide basic training.
Mass advertising campaign of duties and responsibilities

Southwest 1Region

11. Other

12. Other

17. Training that you would like:
knowledge of specific agents and control techniques xx
hazardous material on highways and rail
mass causality
Decon equipment and PPE and methods x
Control and management of emergency situations and all levels of response

18: What training in past twelve months

Training	Who Provided	Total Hrs.
Decon/emergency response	federal, visn 6, AEP	16
none		
hospitals role in emergency preparedness	myself	3
Security fundamentals	In-house	12
Restraints	In-house	1
Disaster policies	ED	1
Drills (BT, mass airport, fire disaster)	In-house	2-12
HASMAT awareness	EPA	16
Principles Emerg. Management	VDEM	20
Homeland Defense	City Police	40
Incident command	VDH	16
Bioterrorism	CMS	8

19. Rate State Training 1= excellent and 5 poor

small pox	3	webcast
state emergency prep. Plan	3	webcast
EMT Instructor	2	
Tabletop exercise 8/03	3-4	
VDH Statewide Drill 10/03	3-4	
Emergency Preparedness Drill	2	
Incident command	2	

20. Useful print or web courses?
Community medical disaster planning and evaluation guide (American College of Emergency Physicians), preparing for mass-casualty incidents (Steven A MacArthur)

FBI
Va health dept posters on exposures and treatment
Post Office
CDC
APIC

21. What 3 actions
    Survey assessment for improvements, publish schedule for training, notify safety staffs throughout state in advance of training (education, communication and networking)
    In hospital training on mutual aid between VDH and hospital, webcast set up in hospital on illness or exposures.
    Educational materials development and distribution
    Funding available for training and salaries
    Only provide equipment when trained to state standards
    Mandate and fund security systems, e.g. lockdown capabilities and trained security personnel.
    Decon training for hospital caregivers
    Fund emergency planner position in hospitals
    Improve communication
    Improve coordination plans between jurisdictions to pool resources when needed

24. If CEUs, what organization?
    Not important
    none
    ENA, ACEP
    VPI
    VA Board of Nursing
    VA EMS

25. Willing to participate in local Medical Reserve Corps?
    No-time factor/demanding schedule
    maybe – more information is needed x
    Yes x

26. What suggestions to develop and implement Medical Reserve Corps?
    Medical students/residents from area colleges and others to serve as part of their professional career
    None
    More info
    Offer financial incentives such as free license renewal, free CEUs to those who need them

Southwest 2 Region

11. Other

12. Other

17. Training that you would like:
    Biohazards
    Specific communication procedures between local agencies and hospitals
    Bioterrorism Readiness for hospital personnel
    Explosive events training for plant safety/security personnel
    PPE training for first response personnel

18: What training in past twelve months

Training	Who Provided	Total Hrs.
Emergency Preparedness	Safety Office	1
Security Assessment	In-House	6
Bioterriorism Drill	VDH	16

19. Rate State Training 1= excellent and 5 poor

Biohazard	2
Far SW planning meetings	3

20. Useful print or web courses?

CDC x

21. What 3 actions
    Statewide plan
    District plan
    Community plan
    Coordination of all agencies in communications
    Training that brings EMS and hospital personnel together so they can work with each other.
    Specific guidelines for reporting and handling all emergencies
    Information on agents, threat level postings and list of preparedness equipment

Provide greater resources to facilities that are in rural areas since facilities are miles apart.

24. If CEUs, what organization?
    Physician
    Nursing
    Large hospital education departments

25. Willing to participate in local Medical Reserve Corps?
    No x
    Possibly

26. What suggestions to develop and implement Medical Reserve Corps?

    None offered

Appendix K

Emergency Department Nurses Focus Group Roanoke, VA October 22, 2003 Summary

1. What is your view of the role of public health in preparedness and response for chemical, biological, and nuclear emergencies?
   Educating the public about what do in emergencies, how to recognize, and who to contact if they suspect something.

   Coordination of more preparedness training for different facilities.

   Planning for manpower and resources to come to an area if an event occurred.

   Planning and setting up mobile stations of on-site decontamination

   Establish an evaluation mechanism so that the after the event, the evalution mechanism was already establish and learning can take place.

   Coordination of regional hospitals about what to do before an event actually happened. What should be done? The example was given of an anthrax scare, and the hospital staff did not know how to proceed.

   There also needs to be coordination on what to do with the local rescue and fire personnel because the public may approach them first.

   How prevent ED from being contaminated and what do you do if it is?

   Education at the time of the outbreak. Public education materials already produced and the means to disseminate via media and other sources are established. Because people are going to come to ER and doctor offices.

   Specific contacts at state level. Who do I contact if I have an event. An emergency preparedness manual with who we contact at state level regarding a specific problem.

   There should be one centralized number to call in the case of an event. Now ED nurses supposed to call VDH, CDC, FBI plus all the people in your local organization that want to be identified.

   Plant a positive vision in people heads if an event happens, e.g. we are going to get through this just like we will 911 and other disasters. Reinforce a positive outcome form the beginning – a belief that we are going to get through this. This reinforces the need for common protocols, standards, and medical, media and public education messages. By being prepared, we may deter bioterriorists in the first place.

2. Are you aware of the means to contact/access the public health system in times of need?
Yes, but a large number of numbers have to be called

Some felt contact information was there somewhere in their facility but not readily available to everyone

There was an opinion that the staff does not know how to use the system.

There was a clarifying question if this was the function of the State or local emergency department. The opinion was that the Sate creates the system of a central number/contact and the hospital has the responsibility to implement.

3. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was your perception of how well the system worked?

Had a TB case and went through infection disease practitioners who contacted the state.

Had a trial run recently, not clear in the actual procedures of what to do, felt that there is need for central coordination.

One participant had to use the Florida's systemand there was lack of coordination in Florida and believes that there could be a similar experience in Virginia.

4. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Readiness activities?

Do not feel that there is much coordination at this time.

The current training seems to be limited to certain personnel, e.g., RNs but LPNs and certain levels of EMTs have not been invited to training.

Several participants agreed that more medical personnel categories need to be involved in training.

Need to train the media in advance of any event and have information and means of dissemination already prepared. In addition, there need to be one central location for the media to get information. The example of anthrax was given where there were many conflicting reports in the media because there was not a single source of information.

Most participants were not aware of any State coordinating activities at this time. One individual shared that most people do not know that there are some state coordination activities going on such as a regional planner and trainer in each region. The state's present coordination activities are not well known to the medical community.

Does the state have the manpower to pull off a coordination effort if an event occurred, e.g., how many people are there to man the phones? This first step of getting information and what to do is a critical step that subsequent activities depend upon.

Prepare the public in advance so they know where to go and what to do.

What is being done to educate and prepare the school systems for these events?

5. How much involvement have you had in Emergency Preparedness and Readiness planning?

Some have had HAZMAT training but most have not had involvement in the planning process for emergency preparedness.

6. The following questions relate to opportunities for assisting local providers:

What areas of EPR training are you most in need of?

Content/information needs: anthrax, containment and how not be contaminated and spread to others, updated MSDS sheets, identification triggers- symptoms, signs, tests-lab work, treatment, how to deal with a large volumes of cases, if drugs are needed- are there adequate stockpiles that are readily available, radiological events and controls, what do with mass power outage

Planning training:

financial aspect of training, outline of protocols so that everyone giving out the same information in all hospitals, coordination of geological location of cases that are occurring at similar time frames to see any patterns and facility that patients are going to, cascade system if a hospital hits capacity- where do you send them, coordinate with other

Coordination training:

Central coordination of training, coordination of what hospitals will be used for different functions, e.g. quarantine,

Methods of training:

Traditional classroom training at distant location that involves other groups as learning is enhanced as participants can learn from each other for a maximum of two days.

More people might be available if training was local with a time period of eight hours. Several tracts could be offered simultaneously so that a number of people could be trained in different skills in the same time period. There training should be repeated on different days to train more people in a facility.

Participants thought that quarterly training would be useful. Perhaps, an initial training and then refresher course.

Most people will not use alternative forms of training such as CD ROMs and websites unless it is mandatory. Interaction in a classroom setting was preferred. CD ROMs and other techniques could be used to reinforce information from the interactive classroom setting.

Currently, CEUs are not important to ED nurses and would become important only if they are mandated for licensure

Useful print or web sources:

Virginia Department Emergency Management, VDEM – can take courses on line

Virginia Hospital and Healthcare Association, VHHA

CDC.gov

Virginia Board of Nursing

7. Would you be willing to participate in a local volunteer Medical Reserve Corps?

There currently is a local volunteer EMS group for this function.

People would be willing but wonder how realistic it will be because ED nurses will be tied up in the hospital giving care.

8. What suggestions do you have for the state in its efforts to develop the implement the Medical Reserve Corps in Virginia?

Some questions were offered:
Will the hospital let you off to do this volunteer work?
Will everyone have the training needed?
Are there models in other states?
What about daycare for parents?

Develop some incentives such as provide training that allow people to move up a level in their responsibly such EMT level, some recognition, perhaps have local business offer discounts to Corps members.

Appendix L

Emergency Department Nurses Focus Group Harrisonburg, VA November 13, 2003 Summary

1.What is your view of the role of public health in preparedness and response to chemical, biological and radiological emergencies?

Organizational efforts to understand research and "Best Practices" regarding preparedness and response

Coordinate and regionalize planning efforts and conduct education and training for providers

Distribution of timely information to healthcare providers: have key contacts at local and state levels that can be accessed by providers, and develop effective communication systems

Provide clarity of the role of VDH relative to providers

Ensure public knowledge of plans to address emergency events

VDH has done alot to improve communication and coordination with providers: participants mentioned drills, forums, and attendance of PH representatives at meetings

It as noted that PH and hospital-based practitioners have "different cultures, " and there is lack of clarity on respective roles in an emergency "event"

2. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Readiness activities?

Continuing lack of 24/7 availability and access to public health, because of different in operating cultures

Lack of clarity on exactly what role VDH will have in an emergency event, and how that will complement /differ from roles of hospital personnel

3. Are you aware of the means to contact/access the public health system in times of need?

Yes, widespread agreement on this. Participants have telephone numbers of VDH personnel and after hours contact numbers to contact public health.

4. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was your perception of how well the system worked?

A few participants noted that HDs were contacted in the past on specific events and that the system seemed to work reasonably well. There has been increased coordination and communication with VDH in last several months.

5. How much involvement have you had in Emergency Preparedness and Readiness planning?

Participants reported that they have had some training, and receive notification of events and approaches to treat via e-mails and through coordination of activities through EMS

6. The following questions relate to opportunities for assisting local providers:

Substantive training areas were identified as follows:

Biological and chemical training, focusing on top "10 " problems, tracking chemical problems, understanding the process for triage in caring for patients with these problems

Evaluation of drills that are conducted

A Site Survey is needed by VDH to assist in helping hospitals profile equipment needs; VDH could also assist in identifying vendors and making "bulk buys" on behalf of providers to ensure the lowest costs in purchasing

Coordination on training with other EDs for coordination in responding to an event, and understanding access to pharmaceutical stockpiles

Methods of training: web-based training and use of CD-Roms are seen as helpful; classroom training was not seen as helpful.

CEUs were seen by all participants as necessary for training programs

Web sites and other resources found helpful: APIC, Emergency Nurses Association, CDC, Emergency Physicians Association

7. Would you participate in a local volunteer Medical Reserve Corps?

No awareness of MRC; there was some belief that forms submitted with RN licensure renewal was part of the MRC effort and participants were not sure

8. What suggestions do you have for the state in its efforts to develop and implement the Medical Reserve Corps in Virginia?

Look to examples that other states have established in terms of their respective volunteer programs, and learn from that

Let hospitals know what expectations are for them in terms of using volunteers and or hospital staff volunteering through the MRC and being deployed in other areas of the state

Local hospitals should be placed in the role of "clearinghouse" for the MRC function as hospitals will be the central resource for screening and treatment in the event of an emergency

VDH must determine the skills levels of volunteers and allocate appropriately in terms of skills that are needed in emergency events

There must be a credentialing function, and VDH could coordinate their efforts with state Department of Professional Regulation to carry out the licensure/credentialing function

There must be provisions for assistance of volunteers under the "Good Samaritan" laws that will eliminate liability issues for state and for volunteers

Other comments: VDH should improve its communication with providers, and focus on educating the public regarding impact of events and necessary action consumers can take.

Appendix M

Emergency Department Nurses Focus Group Arlington, VA January 29, 2004 Summary

1. What is your view of the role of public health in preparedness and response to chemical, biological and radiological emergencies?

Leadership--helping promote awareness and shared information regarding surveillance and serving as a liaison to local providers

Providing effective algorithms for treatment of biological and chemical agents

Communications with the "right" persons at local provider levels, and have a list of Medical Directors of hospital emergency departments in the area

Providing proper diagnoses to local providers through the lab services that VDH coordinates

Be visible and be involved in local preparedness activities and coordination of response

Education of public regarding appropriate action in times of emergency

Educating the private practice physician on recognition and appropriate response

Emergency preparedness system works well- Med Com system has established communication between hospital ERs and local HDs; web-based information system has been established where hospitals submit every ER discharge to HD for their review and analysis; system has improved greatly in recent past

HD has been more active in their coordination with providers during the last two years: providing information and guidance on SARS, participating in meetings at hospitals and with Med Com and Emergency Services Coalition

2. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Readiness activities?

VDDH has received increased dollars and responsibility for activities which is good, but several participants raise the issue as to whether there is enough staff and appropriate staff for a "real" crisis

VDH is regionalizing their activities and the level of support for local jurisdictions is questioned

3. Are you aware of the means to contact/access the public health system in times of need?

Yes, widespread agreement on this. Participants have flip chart numbers of VDH personnel to contact and there is no question on who to contact.

4. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was your perception of how well the system worked?….

Three participants reported having contacted the HD in the past relative to potential problems. These were two anthrax cases and one possible SARs case. These participants reported that the response of the HD was good and there were no problems in obtaining their assistance and helping with the investigation.

5. How much involvement have you had in Emergency Preparedness and Readiness planning?

Participants reported that they have had considerable training

6. The following questions relate to opportunities for assisting local providers:

Substantive training areas were identified as follows:

Training is needed in the areas of recognition of signs and symptoms, and appropriate treatment for specific biological and chemical agents

There is a need for training relative to radiological exposure and how to treat

Methods of training: web-based training is seen as helpful. Classroom training is ok but many demands on time limit this possibility. HRSA grant training is also occurring and needs to be coordinated with any training that VDH would be providing

CEUs were viewed by all participants as necessary to motivate ER staff to participate in training

Web sites and other resources found helpful: APIC, Emergency Nurses Association, CDC, Emergency Physicians Association

7. Would you participate in a local volunteer Medical Reserve Corps?

No one in group was familiar with the MRC concept

8. What suggestions do you have for the state in its efforts to develop and implement the Medical Reserve Corps in Virginia?

Staffing issues, and how VDH plans to staff the MRC

Surge capacity issues and a plan for quarantine of hospitals

Define scope of responsibility for volunteers

Ensuring that volunteers have proper training

Establish a process for credentialing and making sure of qualifications of volunteers

Establish a listing of retirees that could be used if/when necessary

Recognize that volunteers have concerns about the safety and security of their own families, and that this fact may limit volunteers' availability in times of need

Appendix N

Emergency Department Physicians Focus Group Abingdon, VA October 16, 2003 Summary

1. What is your view of the role of public health in preparedness and response for chemical, biological, and nuclear emergencies?

   Be a resource and have a leadership role

   Organize the response system to notify what the agent is and coordinate the other services.

   Coordinate the media messages so that the public and medical community hear the same thing.

   A central role of planning and integration

   A communication role providing specific directions to the public, e.g. should I stay at home or not, link information to different hospitals.

   The public should be trained/programmed early on what to do and information already in pamphlet and other forms.

   An organization of hospitals ahead of times as regards their specialty of treatment so that primary communication will be with the public. For example, some be better ready to handle chemical versus biological events.

   Communicate with the community ahead of time about what facilities/services are available.

   Expand the planning to the home setting; the ED staff could go to the home setting.

   Identify key people that the EDs are to contact.

2. Are you aware of the means to contact/access the public health system in times of need?
   There are numbers for local health departments, CDC, and FBI. One participant had the cell phone number of the public health director.

   What happens if no phones are operative? There was the suggestion to have specially trained individuals in each hospital who could be reached if no phones could be used. Other suggestions included developing contacts with local ham radio operators. If the phones do not work, there may be communication locally via radios but to outside areas to get information and assistance.

The participants generally feel comfortable with the current system if the phones work.

3. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was your perception of how well the system worked?

One individual was involved with a possible anthrax exposure in Roanoke (2 hours north) and the system worked well. They notified the local health department and CDC and the worker never entered the ED.

Some feel that they are not adequately prepared and equipped.

4. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Readiness activities?

The Southwestern part of Virginia is being ignored in having training provided. There have been trainings in Roanoke; however, this is a two and one-half hour drive for Southwestern Virginia physicians and is hard for them to do.

Do not know what the State is doing except what is required by State licensing.

The State is focusing on larger metropolitan areas for possible targets and small, rural areas are being ignored. There is always a focus on the last event. The next event could be in a rural area, e.g. the Radford Arsenal.

One participant has received a newsletter from the VDH but has not had formal contact from reliable sources.

The State could have a drill for communication and establishing protocols and guidelines.

Need to identify for the emergency team who does what, review this plan periodically and as people change responsibility.

Now, there is no major coordination being done in this area. Some hospitals have policies where specific people have roles, and after 911, there were task forces formed at the county level, but there has not been a regional approach.

In this area, physicians may not live near hospitals and not be able to get to an massive emergency.

One participant commented that there is going to be a drill for medical examiners.

The State needs to make sure that people in public health know what is available.

There is a SW Emergency Preparedness Task Force that is planning a drill.

Need a clear delineation of responsibilities of what the health departments, different hospitals in the region, and the staff within the hospitals is to do with a biological, chemical, or nuclear event.

5. How much involvement have you had in Emergency Preparedness and Readiness planning?

After 911, there was countywide planning but no widespread regional planning.

There is a grant for the region that is primarily looking at what equipment is needed rather than overall planning. This is a "what is needed mode" and then need to switch to the "how use it mode."

One hospital in the region had had a meeting to determine what events should be handled by different hospitals in their area.

6. The following questions relate to opportunities for assisting local providers:

What areas of EPR training are you most in need of?

Crowd control, how to decide to lock down the ED and what do with the staff and patients that may or may not already be contaminated, how do you prevent staff from being contaminated?, personal protection equipment and how get it ready, antidotes, vaccines, antibiotics to be used, nuances of decontamination, risk assessment of patients to protect personnel providing treatment, how deal with acute radioactive exposure, identification of chemicals of people in check in and treatment, EMS personnel need this training also, what is the incident command response- what are the different levels of responsibilities and who in charge at each level?,

Planning training:

Be familiar with law enforcement plans, will they take over and coordination with FBI and CDC- i.e. who will be in charge?

A seminar on how to plan for these events.

Get information for planning on the analysis of reactions to previous disasters; what was learned, what systems broke down, what worked and did not work

Coordination training:

A reporting system established that can see the overall regional pattern of what events are happening – the who, what, where and when of the cases to see any pattern.

Methods of training:

Interactive email on specific topics that would take about 15 minutes for each for example weekly topic. There would be information and then a quiz at the end and a link to similar topics.

Consider the culture in designing the programs. For example, Appalachian EMS personnel like to have training around sandwiches and chips. These individuals will not want to sit alone at a computer.

The preference was for traditional classroom training with interactive exercises. Some physicians may respond to CD Roms and web-based information but most physicians want the option of face to face hand on training.

In order to participation in web-based learning, it is going to have to be mandatory. For example, you would have to complete a certain module on the Board of Medicine website to be recertified.

With any training, there will soon be a loss of knowledge. Therefore, we need to develop a "just in time" training information system that the physician can go to as needed.

There was general agreement that being sent a CD ROM requires self-discipline and time availability and that CD ROMs would probably not be used unless completion of the CD ROM was a condition of licensure. One physician offered that the CD ROM sits on the table and gradually creeps to the trashcan.

If print source were used, would be more likely to read something like a medical letter that 4-5 pages long rather than a long article.

Audio digest information with a page of questions to be sent in for CEU's are useful.

Physicians would want CEUs.

Organizations that could sponsor CEUs

American Academy of Family Practice
The Medical Schools in Virginia
American Academy of Emergency Physicians

Useful print or web sources:

Audio Digest through the Californian Medical Society
CDC
Board of Medicine Website
Gideon Website is useful for identifying infectious diseases

MD Consult
Hippocrates

7. Would you be willing to participate in a local volunteer Medical Reserve Corps?
There were a number of questions that was listed in number 8.

8. What suggestions do you have for the state in its efforts to develop the implement the Medical Reserve Corps in Virginia?

What is the time frame for volunteering? What are the expectations of service?

Need to have the coordination of all these people ahead of the event?

There could be a consortium of people for Southwestern Virginia?

Are there any State licensing issues?

Appendix O

Emergency Department Physicians Focus Group Richmond, VA October 16, 2003 Summary

1. What is your view of the role of public health in preparedness and response to chemical, biological and radiological emergencies?

VDH needs to be the resource to assist hospitals and other providers during first 72 hours after an event, then state level assistance, then federal assistance in next 72 hours

Leadership on Emergency Preparedness and Readiness

Provide training and education for providers:
- on recognition and treatment of emergency events
- provide summary information that distills best practices in terms of recognition and treatment

VDH doesn't provide treatment, but rather looks at the context of "sick person;" there needs to be a partnership between local physicians who care for individuals and VDH who really don't have the clinical expertise; there should be VDH physicians who have the clinical expertise to share with local physicians and other providers

Provide public education and create positive public expectations and positive public behaviors

Providing clinical findings and best information on how to treat individuals in an emergency

Conduct surveillance and outbreak investigations as well as investigate possible events

Conduct pre-event assistance

Be available and on-call during an actual event

VDH should not be the only organization providing leadership in an emergency event (Va. Dept. of Emergency Management was also mentioned)

VDH should be working with hospital physicians to provide assistance (Richmond area hospitals have a system of communication called HELICS which is used to deploy resources in an emergency)

Assist in purchase of equipment needed by hospitals (Decon, PPE, etc.)

Provide a plan for pharmaceutical distribution (participants were unsure if there is a plan and if so, how that plan will be implemented)

Coordinate statewide disaster training

Educate private practice physicians on emergency preparedness and response—these private practice physicians in many cases will be on the front-lines of dealing with exposures

2. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Readiness activities?

General lack of awareness of what VDH has done/is doing—has not been communicated to physicians

Physicians report that they don't have the tools to do the job—vaccines, ventilators, equipment

No addressing of issue of "surge capacity" by VDH

Need plan for control and distribution of pharmaceuticals, so that every hospital has a supply of appropriate vaccines/meds rather than waiting on distribution after an event

Need to have a single "800" number to provide access to VDH personnel; it is cumbersome to have hospital personnel go through District Health Director who then contacts state

Effectiveness of assistance by VDH has been poor

VDH needs to come and mingle at the "doctors dining rooms" to develop personal relationships and put faces with names

3. Are you aware of the means to contact/access the public health system in times of need?

Yes, widespread agreement on this, due to weekend access numbers, telephone number of VDH epidemiologist and state toxicology laboratory; also have telephone numbers and beeper numbers to access VDH in event of emergency

4. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was your perception of how well the system worked?

Two participants noted that VDH had been called for rabies incidents. In general, though, it was stated that access has been poor.

5. How much involvement have you had in Emergency Preparedness and Readiness planning?

Participants indicated that they have collectively had considerable training, in the form of drills and classes provided at their hospitals. Participants spoke of their active preparedness groups at their hospitals. Two participants had no or very limited training.

It was noted that physicians don't rely on VDH for training, to-date. Participants were unaware of any training that has been provided by VDH

6. The following questions relate to opportunities for assisting local providers:

Substantive training areas were identified as follows: chemical and radiological exposures; managing proper dosages of antibiotics and vaccines in children

Managing public education was seen as important by the participants

Methods of training: "Hands-on" training was seen as highly desirable, combining traditional classroom training with disaster simulations/drills (VDH should come to hospitals and tailor training); web-based methods were also viewed as very effective means of training

CMEs would be helpful and would appeal to physicians; should be offered through teaching hospitals. Relevance is the key for training

Resources that were seen as helpful: ACEP, CDC (one participant noted that not sure VDH can top this); hands-on drills

7. Would you participate in a local volunteer Medical Reserve Corps?

Half of the participants had heard about the MRC concept and believed that it was a good idea for Virginia to explore this. Level of participation is uncertain.

8. What suggestions do you have for the state in its efforts to develop and implement the Medical Reserve Corps in Virginia?

VDH needs to clarify the role of MRC in terms of what specific volunteers would do

Surge capacity issues need to addressed through MRC, and financial resources are needed to get the concept implemented

First 72 hours is when volunteers would be needed; after that state and FEMA officials would be activated for an event

Nurses and other health care professionals who are single Moms will NOT come in for a BT event; this is just a reality that state must address

Other comments: there needs to be clarification of roles of VDH and hospital-based physicians as to who does what and what expertise is brought to the table

Appendix P

Emergency Department Physicians Focus Group Virginia Beach, VA February 5, 2004

Summary

1. What is your view of the role of public health in preparedness and response to chemical, biological and radiological emergencies?

Providing accurate and rapid information in times of an event

Providing effective communications among health department staff and with providers, and effective communications between VDH and CDC

Educating the public and communicating with the public

Distribution of resources to hospitals such as medications and equipment in times of need

Work with hospitals in coordinating preparedness activities (educate hospital staff, and identify and implementing a system for response)

VDH role needs to be broken down into: pre-event (surveillance, education); event (distributing resources and taking action) and post-event (follow-up, tracking, evaluation)

Manage volunteers (identify ancillary staff, establish a rapid credentialing process)

Identify local agents and establish proper prophylaxis and quarantines

VDH should acquire appropriate legislative powers to do the job (financial resources, equipment, legislative authority to quarantine a hospital, etc.)

2. What concerns do you have with the state's public health efforts to coordinate Emergency Preparedness and Readiness activities?

Communications need to be strengthened within VDH and between VDH and facilities—no single source of information at VDH which causes problems at times

Lots of progress has been made by VDH in working with providers and working with local hospitals and providers, and there has been significant accomplishment in preparedness training and coordination for emergency events

Needs to be communications from VDH to key contacts at local hospitals so that there is control; further, is was suggested that text pagers or other means could be used, and it

was noted that plans are underway for hospitals in the area to have radio systems to allow communication between VDH and each hospital

Needs to be evaluation and follow-up of statewide and local drills conducted by VDH: two participants noted that no follow-up was provided after the drill in the Fall.

CMEs should be granted to physicians for participation in drills and other educational activities

Hospitals seem to be "on their own" to meet expectations for preparedness and to figure things out for themselves without much assistance from VDH

VDH is characterized by bureaucratic structures that take time to get things done

Unfunded mandates are hard to meet – PPE, training, equipment

HIPAA requirements and what providers need to do in terms of preparedness activities

Liability issues of local agents (smallpox exposures)

Financial resources seem to be tied up in Richmond and can't get distributed to local providers

3. Are you aware of the means to contact/access the public health system in times of need?

Yes, widespread agreement on this, due to weekend access numbers, telephone number of VDH epidemiologist and state toxicology laboratory; also have telephone numbers and beeper numbers to access VDH in event of emergency

4. In the past, have you had an occasion to contact the public health system in an emergency, and if so, what was your perception of how well the system worked?

For the most part, response of VDH has been good in past on occasions when assistance was requested. Incidents identified included rabies exposure, hepatitis, possible West Nile, and influenza. Two participants noted that responses from VDH at night seem to be "lagged."

5. How much involvement have you had in Emergency Preparedness and Readiness planning?

Participants indicated that they have collectively had considerable training, in the form of drills and classes provided at their hospitals. Participants spoke of their active preparedness groups at their hospitals.

It was noted by several participants that it is difficult for physicians to commit to training, even though training is viewed as positive; Too many demands on their time and all of this is on top of what they do in their regular jobs—taking care of sick patients

VDH teleconferences were noted as helpful; One local District HD made copies of the CDC teleconference and made available to physicians

It was noted that training programs being developed by MCV (using Georgia program) will be made available in the future

It was pointed out that training efforts should include 1) initial training; and 2) refresher training, given that knowledge fades since events may be few and far between

It was noted that physicians don't rely on VDH for training, to-date

6. The following questions relate to opportunities for assisting local providers:

Substantive training areas were identified as follows: need to have inventory of resources available for training (it was pointed that the local emergency coalition – MMRS- will be coordinating training activities for all hospitals over next two years); training dealing with surge capacity and alternate care sites, as well as identifying the resources of VDH for use on-site in the event of an emergency, were noted. There should be VDH teams identified and used in local drills

Methods of training: classroom training was not seen as helpful due to time demands placed on physicians; self-training using CD Rom and DVD were seen as helpful, as well as web based methods using web casts and web-based instructional materials

CMEs were viewed by all participants as necessary to motivate physicians to participate in training

Web sites and other resources found helpful: emedicine.com, CDC website, AAP (American Academy of Pediatrics), USARAID web site.

7. Would you participate in a local volunteer Medical Reserve Corps?

Only one in group had heard of it, and knew its purpose.

8. What suggestions do you have for the state in its efforts to develop and implement the Medical Reserve Corps in Virginia?

Concerns as to how it differs from DMAT and other local volunteer efforts (VDH needs to clarify this with health care provider community)

Fund it properly

Focus clearly on competencies and credentials for participants (want volunteers to have the latest, up-to-date skills and knowledge)

Check backgrounds of volunteers

VDH should establish a centralized data bank of approved volunteers so that volunteers can be quickly accessed in times of need and so that emergency rooms of hospitals can know in advance of additional resources that they can count on

VDH needs to have special ID badges for all volunteers to enable participation and to be allowed to enter facilities and emergency set-up areas.

Other comments: VDH needs to know that hospital Emergency Rooms are “Maxed out” in terms of the demands on them. Even though all ERs know that EP and R issues are very important, they are burdened with the demands of their patients with little time and capability to get up to speed. Participants acknowledge this is a special and on-going challenge. Hospitals need help from VDH --as much as they can get.